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MEDICARE FRAUD AND ABUSE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JULY 31, 1995

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MEDICARE FRAUD AND ABUSE

MONDAY, JULY 31, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:40 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Grassley, Conrad, and Graham.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. I think we will start without Senator Cohen. So we can go to our panel of June Gibbs Brown; Sarah Jaggar, Charles Owens, and Paul Van de Water.

We will take you in the order that you are on the witness list. So first, we will take Hon. June Gibbs Brown, who is the Inspector General for the Department of Health and Human Services.

STATEMENT OF HON. JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. BROWN. Thank you, Senator.

The CHAIRMAN. Thank you.

Ms. BROWN. I will focus my remarks today on fraud in the Medicare program and the savings that can be achieved through aggressive efforts to reduce fraud, waste and abuse.

I would be remiss, however, if I failed to mention that your cosponsorship of the Medicare and Medicaid Patient and Program Protections Act of 1987, which was instrumental in the enactment of many of the administrative remedies provided to us for sanctioning aberrant health care providers and practitioners.

As a result of this Act, the number of administrative sanctions imposed by the Office of Inspector General has increased by over 300 percent. From 1983 to date, our office has excluded over 9,000 health care providers and practitioners, and only about 25 of these have been overturned in the administrative and judicial review process.

Despite our efforts, it is clear that health care fraud and abuse is still increasing. Vulnerabilities in three specific program areas—home health care agencies, nursing facilities, and medical equipment and supplies—have been of particular concern to us recently.

A new effort called Operation Restore Trust has been established to target these areas. My written statement discusses each area in detail. In the interest of time, however, I will limit my remarks to home health care services.

In fiscal year 1990, the Medicare program spent $3.3 billion for home health care. Program expenditures are expected to reach $14 billion this year, a four-fold increase. We believe that part of this increase may be the result of fraud.

For example, we found that in one home health agency they claimed approximately $14 million in unallowable costs during one cost reporting year. Some of those unallowable costs included utility and maid service payments for the owners of condominiums, and golf pro shop expenses and lease payments on a luxury car for the owner's son at college.

In another Home Health Agency that we audited, we found that 75 percent of the claims, more than $25 million submitted, did not meet the Medicare guidelines.

We reviewed a sample of home health care claims in Florida and found that 26 percent, on average, of those claims did not meet the Medicare guidelines.

The CHAIRMAN. Say that again.

Ms. BROWN. When we reviewed a sample across the board of home health care agencies in Florida we found that 26 percent of their claims did not meet the guidelines.

The CHAIRMAN. 26 percent in terms of dollar volume, or 26 percent of the numbers of claims.

Ms. BROWN. Dollars.

If you were to ask, what is different today from several years ago in the health care fraud and abuse enforcement arena, I would make three observations. First, rising Medicare and Medicaid expenditures create a more attractive target for unscrupulous individuals. In 1980, Medicare program costs were $34 billion, but estimated program costs for 1995 are $177 billion.

Second, the fraud schemes are demonstrating increased sophistication and complexity involving groups of perpetrators, large national corporations, and huge dollar amounts. In the last year, our fraud cases included settlements with National Medical Enterprises, for $379 million; and CareMark International, Incorporated, for $161 million.

The third point is that inadequate resources are available to address the problem of health care fraud and abuse despite increasing demands. The OIG's investigation and audit resources have declined during the past several years. As a result, we have had to close 17 Office of Inspector General investigative offices and we now lack a presence in 24 States.

As you can see from our chart, over the last 5 years every dollar devoted to OIG investigations of health care fraud and abuse—and this is just in this investigative area—has yielded a return of nearly $7 to the Federal Treasury, Medicare trust funds, and State Medicaid programs. That is a return of 7:1. In fiscal year 1994 alone, the return was $14 for every dollar spent in health care investigatory efforts.

The return on investigative activities, however, is only part of the story. Since 1981, the estimated overall return on Federal in-

vestment in OIG has totalled over $59 billion in fines, restitution, settlements, receivables, and savings to the Federal Government. The bulk of these savings are due to audits and evaluations of the department's programs.

Last year alone, the OIG generated fines, restitutions, penalties, receivables, and savings of over $8 billion, or over $80 for every dollar appropriated for our office.

The Secretary of Health and Human Services has been very supportive of our need to adequately fund activities to combat health care fraud and abuse. But, because of the difficulty in obtaining adequate resources to address health care fraud and abuse, we support a mechanism whereby certain recoveries generated by our health care anti-fraud activities would be deposited in a reinvestment fund, with dollars available to fund additional enforcement efforts.

Thus, the individuals who actually perpetrated fraud against, or otherwise abused our Nation's health care system, would foot the bill for increased policing of these programs. Because these funds would yield substantial savings to the Medicare and Medicaid programs, the Federal deficit would be decreased rather than increased by using this mechanism.

This concludes my oral testimony, and I would be happy to answer any questions.

The CHAIRMAN. Is what you are asking similar to what the IRS asks from time to time in terms of enforcement, if they can have the enforcement funds dedicated to further enforcement they could do a better job?

Ms. BROWN. There is a similarity. However, in some cases, there is widespread, organized-crime type fraud against the medical system of our Nation and I think it is an extremely serious problem. We believe that a mechanism similar to what I have described would have a substantialdeterrent effect.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Brown appears in the appendix.]

The CHAIRMAN. Next, we will take Sarah Jaggar, who was with us last week, were you not? You did so well, we would like you to come back the last three weeks in August.

Ms. JAGGAR. I will be right here.

The CHAIRMAN. Go right ahead. It is good to have you with us again.

STATEMENT OF SARAH F. JAGGAR, DIRECTOR OF HEALTH FINANCING AND POLICY ISSUES, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. JAGGAR Thank you very much. Good morning, Mr. Chairman and members of the committee. I am pleased to be here today to discuss problems of waste, fraud and abuse in the Medicare program.

As we have documented in numerous reports and other Congressional testimony, we believe that billions of dollars could be saved by curbing questionable, abusive, and exploitative billings.

Today I would like to talk about the factors that make Medicare particularly vulnerable to abuse and about the health care manage-

ment strategies used by the private sector to deal with similar problems.

I would like to summarize my statement and request that the full statement be submitted for the record.

The CHAIRMAN. Without objection.

Ms. JAGGAR. Thank you.

[The prepared statement of Ms. Jaggar appears in the appendix.]

Ms. JAGGAR. In brief, we have found that Medicare's continuing vulnerability stems from a combination of factors. First, higher-than-market rates for certain services; second, inadequate checks for detecting fraud and abuse; third, superficial criteria for confirming the authenticity of providers billing the program; and fourth, weak enforcement efforts.

Enhancement of payment controls to ensure effective fraud and abuse detection is difficult. Contractor resources are a major factor in doing this. Medicare contractors process about 800 million claims annually. However, on a per claim basis, their funding for safeguard activities has declined in recent years so that today fewer than 5 percent of all claims are subjected to review.

In fact, per claim funding for these activities has been reduced by 44 percent since 1989. As a consequence, we have found instances where automated controls that flag claims for further review have been turned off for lack of staff to follow up.

Another problem is that providers who defraud or otherwise abuse health care payors have little chance of being prosecuted or having to repay fraudulently obtained money. Although administrative and legal tools are available to Medicare, few cases are pursued. Even when they are, many are settled without conviction, penalties are often light, and providers frequently continue in business.

The private sector faces the same types of fraudulent schemes and abusive billing patterns. Ironically, until the early- or mid-1980's, the private sector lagged Medicare in techniques of fighting fraud, but in the past decade private payors have taken the lead by shifting toward an approach of vigilant management of care and costs.

To price health care, they assess the market options. To detect manipulation of billing costs and billing codes, they use state-of-the-art software. To monitor excessive utilization, they use computerized systems. To screen providers so they only deal with legitimate ones, they use pre-admission review and preferred provider networks.

If HCFA were able to apply these techniques to Medicare, the program's weaknesses could be significantly remedied. Medicare's current pricing methods and controls of over-utilization, which were consistent with health care financing and delivery 30 years ago, are not well-aligned with today's major financing and delivery changes.

To some extent, the predicament inherent in public programs, the uncertain line between adequate managerial control and excessive government intervention, helps explain the dissimilarity in the way Medicare and private health insurers administer their respective plans.

Given the current emphasis on fiscal discipline, the pay-and-chase approach targeting abusive providers will continue to fail behind the demands that are placed upon it. Instead of these downstream efforts, we believe Medicare should emphasize pre-enforcement techniques, or follow an upstream approach.

Such an approach would include the following strategies. First, allow Medicare to price services and procedures more competitively. This could include streamlining processes required to revise excessive payment rates and competitively bidding and negotiating prices.

Second, enhance Medicare's fraud and abuse detection efforts. This could include completing the modernization of Medicare's claims processing and information management systems and expanding the use of state-of-the-art computerized controls.

Third, require providers to demonstrate their suitability as a Medicare vendor before being given unrestricted billings rights. This could include HCFA's establishment of preferred provider networks, development of more rigorous criteria for authorization to bill the program, and use of private entities to accredit providers or certify their legitimacy.

Mr. Chairman, this concludes my statement. I will be pleased to answer any questions.

The CHAIRMAN. Thank you very much.

Now we will take Charles L. Owens, who is the White Collar Crime Section Chief, Criminal Investigative Division of the Federal Bureau of Investigation.

I believe this is the first time you have been before us, is it not?

Mr. OWENS. It is, sir. Thank you.

The CHAIRMAN. Welcome. Good to have you with us.

STATEMENT OF CHARLES L. OWENS, WHITE COLLAR CRIME SECTION CHIEF, CRIMINAL INVESTIGATIVE DIVISION, FEDERAL BUREAU OF INVESTIGATION, WASHINGTON, DC

Mr. OWENS. Good morning, Mr. Chairman and other members of the committee. It is a pleasure for me to be here today representing the FBI as your committee addresses the issue of Medicare fraud.

As you know, health care fraud and abuse may account for as much as 10 percent of all health care expenditures, or as much as $100 billion this year. Not all health care professionals defraud or abuse the health care system. Unfortunately, however, we are seeing a rise in the infiltration of the health care system by corrupt individuals who victimize citizens with health care fraud schemes set in motion solely by greed.

I want to emphasize three points today. First, the FBI is seeing extraordinary growth in the numbers of investigations under way, with limited resources to address the problem. Second, the FBI has a health care fraud strategy. Third, as illustrated through case studies, health care fraud is a serious crime problem that severely impacts the financial structure of the Nation's health care system.

The FBI has nearly 2,000 active health care fraud investigations. This represents an increase in investigations of over 500 percent since 1991. At the same time, most of our field offices report unaddressed health care fraud cases. The Nation cannot afford a

piecemeal approach to health care fraud when we are facing a crime problem the magnitude of health care fraud.

Therefore, the FBI has developed a national strategy designed to produce a long-term, far-reaching positive impact on the problem. The six elements of the FBI's national health care fraud strategy are:

One, dedication to a team approach in addressing health care fraud with appropriate federal, State, and local agencies through utilization of task forces and working groups.

Second, regular utilization of sophisticated investigative techniques, such as undercover operations and electronic intercepts to efficiently and effectively combat the problem.

Third, aggressive use of asset forfeiture and money laundering statutes to eliminate the fruits of the criminal activity.

Fourth, the effective use of criminal, civil, and administrative enforcement. The FBI has greatly expanded its civil investigative effort in these matters.

Fifth, formulation of what the FBI calls National Initiatives. National Initiatives are investigations having a national scope. Two methods are used to create these initiatives. The first method is to consolidate similar cases which are being investigated by several FBI field offices, a concept we call batching.

An example of this approach is the recently-surfaced investigation code name Sudden Impact, which addressed staged automobile accidents, in which over 500 persons have been arrested, with over 300 of those individuals having plead guilty to date.

The other type of initiative consists of large-scale proactive investigations of health care providers with facilities across the Nation. An example of this type of initiative is the investigation of National Medical Enterprises which own psychiatric hospitals located in numerous States.

Finally, the FBI identifies specific geographic areas where fraud is apparent and develops an investigative approach to combat it. For example, 10 percent of our Medicare dollars are spent in the State of Florida, and Dade and Broward Counties alone account for one-half of that amount, or 5 percent of the Nation's total expenditure.

Our Miami office recently reported that they had 270 unaddressed investigations of health care fraud. In response to that backlog of unaddressed work, FBI headquarters has recently authorized Miami to establish a second health care fraud squad dedicated solely to the investigation of health care fraud matters.

My prepared statement, which we request be made a part of the record, highlights examples of cases that illustrate the seriousness of the health care fraud problem. In the interest of time, I will not restate those at this point.

The Attorney General has named health care fraud enforcement the Number Two initiative of the Department of Justice, behind violent crime. We intend to be very aggressive in our efforts to combat this problem.

Congress can assist the FBI and those other agencies charged with investigating and prosecuting individuals who prey on our health care system. We endorse efforts by this Congress to

strengthen criminal, civil, and administrative remedies for health care fraud.

A number of legal weapons are not presently available to us. For example, there is not a specific health care fraud offense. The FBI does not have administrative subpoena authority in health care fraud investigations. The Anti-Kickback Statute is applicable to just the Medicare and Medicaid programs, and certain health care fraud schemes are not covered under money laundering statutes. These and other measures would give us additional tools needed to combat the escalating crime problem.

Mr. Chairman, that completes my initial remarks and I would be happy to answer any questions following the remaining remarks.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Owens appears in the appendix.]

The CHAIRMAN. We will conclude with Paul Van de Water, who is the Assistant Director for Budget Analysis of the Congressional Budget Office, who I think has been before us before.

Dr. VAN DE WATER. Yes, Mr. Chairman.

The CHAIRMAN. Good to have you with us again.

STATEMENT OF PAUL N. VAN DE WATER, PH.D., ASSISTANT DIRECTOR FOR BUDGET ANALYSIS, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. VAN DE WATER. Thank you. Mr. Chairman, Senator Grassley, I am pleased to represent CBO at this hearing on fraud and abuse in the Medicare program.

The budget resolution assumes that the Congress will take actions this year to reduce the growth of Medicare spending by $270 billion over the 1996–2002 period. As the Congress considers alternative approaches to meeting that target, it is confronted by claims that health care fraud, waste, and abuse may represent 5 percent—or even 10 percent—of health care expenditures. If applied to Medicare, those percentages would represent spending of $10 billion or $20 billion every year.

Such figures, however, cannot be translated directly into budgetary savings for three reasons. First, estimates of potential losses from fraud, waste, and abuse are highly speculative. If the Health Care Financing Administration and private insurers had good information about the extent of the problem, they would know how to eliminate it and would already have taken steps to do so.

Second, the large figures cited include spending that is considered abusive or wasteful, not just spending that is fraudulent and illegal. No clear line separates abusive activities from fraud, and distinguishing between spending that is wasteful and spending that is appropriate is even harder.

Third, fraud and abuse are not easily trimmed from the edges of the program but are marbled throughout the system. In Medicare, as elsewhere in the Federal budget, there is no line item labeled "fraud, waste, and abuse."

Nonetheless, despite these caveats, many proposals to reduce fraud, waste, and abuse can produce quantifiable budgetary savings. For convenience, those proposals may be divided into three groups.

The first category of proposals involves changing elements embedded in the structure of Medicare that lead to excessive spending, particularly the emphasis on unmanaged fee-for-service care and cumbersome procedures required to revise certification requirements and payment rates.

For example, several of the panelists here this morning have made some specific proposals, including the following: revising reimbursement mechanisms for post-acute care services, including skilled nursing and home health; contracting with selected providers to provide specific services; allowing or requiring competitive bidding for certain durable medical equipment, diagnostic tests, and other goods and services; using preadmission review, case management, and other techniques to control the use of expensive services; and providing financial incentives for beneficiaries to use preferred provider networks.

The savings to be achieved from each of these proposals would, of course, depend their precise specifications and the language of the legislation.

The second group of proposals would provide additional tools for law enforcement officials to use in their efforts to combat fraud. Mr. Owens made several suggestions this morning. Those and others include establishing health care fraud as a Federal criminal offense, strengthening sanctions in the Medicare program, increasing civil monetary penalties for health care offenses, and expanding the scope of money laundering and anti-kickback statutes.

Estimating the effects of such proposals on Medicare spending is extremely difficult, but even if data are scanty, CBO will provide the best possible estimates using the information that is available.

Proposals in the third group would increase the amount of resources available for payment safeguard activities and law enforcement. Several considerations limit the savings to be expected from such initiatives.

No savings should be expected without assurances that the funding intended for specific initiatives will increase total spending to protect program integrity, and that the higher level of real spending will be maintained in future years. By creating a permanent appropriation for payment safeguards, the administration's proposal would take a major step in that direction.

Even with assured funding, however, and with some evidence of the savings achieved by past efforts, the amount of savings from such proposals is uncertain because diminishing returns are sure to set in as additional resources are devoted to enforcement activities.

I hope these comments give you a good idea of CBO's approach to issues of fraud, waste, and abuse in Medicare. I look forward to your questions.

[The prepared statement of Dr. Van de Water appears in the appendix.]

The CHAIRMAN. Dr. Van de Water, let me ask you this. The other three witnesses seemed to indicate that the fraud and abuse is not just occasional, but almost endemic, perhaps more so in some specific types of programs than others, but widespread.

If you were drafting legislation to attempt to remedy that, to correct it, to catch it, what are the main points you would put into

it, and especially what would you put into it so that CBO would score it?

Dr. VAN DE WATER. I would focus on the second and third of the three groups of proposals that I laid out. Of course, in doing so, CBO would have to consult very closely with the experts in these matters, such as the Inspector General and Mr. Owens and his staff.

But the focus would need to be, first, on providing the additional tools that the law enforcement officials believe would be appropriate, such as the ones Mr. Owens enumerated, and second, on developing some assured, consistent method of funding for these payment safeguard and program integrity efforts that would be consistent with the Budget Act.

The CHAIRMAN. Now, tell me what is wrong with Ms. Brown's chart, where she has got, in 1993 and 1994, savings of 13 or 14:1, as I recall. 11:1 and 14:1. Is that speculative, or is that quantifiable?

Dr. VAN DE WATER. The figures in the right-hand column, from what we can tell, seem to be pretty firm figures. Ms. Brown did mention larger figures, but they take in program evaluations and audits, as she said, and not simply the returns from investigative activities. But the 14:1 or 7:1 return ratios are fairly firm numbers, we believe.

The CHAIRMAN. Now, come back again. Clearly, we are going to meet our totals of the $270 billion. To the extent we can help meet them by tightening down on fraud and abuse, that is well worth doing. But I need to know specifically what CBO will score and what they will not. I know it is speculative, because I have been through this with the IRS before.

But it is clear there are savings to be made. You cannot have this degree of fraud and abuse without being able to save something. And I know CBO has been reluctant to score it in the past. I just need some very specific suggestions from you that say, if you do A, that is worth $8 billion, if you do B, we would score that at $9 billion, if you do C, here is an additional $3 billion. Is that possible to do?

Dr. VAN DE WATER. It is possible, but I cannot do that for you right now because you are the people who develop the proposals and we are the ones who estimate them.

The CHAIRMAN. But I am trying to reverse the process. [Laughter.]

Dr. VAN DE WATER. I was trying to——

The CHAIRMAN. To reverse the process.

Dr. VAN DE WATER [continuing]. Reverse the process, yes. I do not simply want to state what I said before, but, again, CBO has always maintained that if the Congress provides administrative officials with new tools, whatever they may be, those sorts of proposals are scorable.

In the past couple of years, the one that comes to mind, that I am sure you are familiar with, is a proposal allowing the government to withhold tax refunds for delinquent student loans. You used that proposal, as I recall, to help fund some extended unemployment insurance benefits a few years ago. That is an example of a new tool. Perhaps setting up health care fraud as a distinct

Federal criminal offense might be a new tool that could produce quantifiable savings.

The CHAIRMAN. Is one thing you would need a dedicated fund rather than an appropriated fund?

Dr. VAN DE WATER. Yes, that seems to be clear. In my written statement, although not in my oral remarks, I went into what was perhaps tedious detail on the Budget Act issues involving the distinctions in scorekeeping between discretionary and mandatory spending. One of those scorekeeping rules, which is enshrined in the conference report on OBRA 90, states that CBO is not to change estimates of spending for mandatory programs as a result of changes in discretionary appropriations. A dedicated permanent funding source would presumably get around that scorekeeping requirement.

The CHAIRMAN. Ms. Jaggar, you mentioned that up until, I cannot remember if you said early 1970's or late 1970's, the private market was behind the government, but since managed care has come in, they have been getting better and tighter about monitoring. Do I quote you right on that?

Ms. JAGGAR. Yes, sir. I think I said mid-1980's, not 1970's.

The CHAIRMAN. All right. I apologize.

But the managed care entities have gotten better at it than we have. Does that mean that the degree of fraud and abuse is greater in the government managed programs than in the straight-out private managed programs.

Ms. JAGGAR. Senator Packwood, I do not believe the estimates for fraud in the private world are any more precise, if you will, than they are in Medicare and Medicaid. In all instances, the numbers that are cited loosely by all of us seem to be a consensus of experts.

What I was trying to emphasize is that private insurers, not just managed care but also people who still do fee-for-service work, have an arsenal of tools, as it were, available to them that allow them, more readily than the Health Care Financing Administration can, to take actions against entities that appear to be performing in a fraudulent or abusive way. Also, those tools allow them to set up criteria for participation in their programs that discourage fraud and abuse.

So, my real emphasis is that we recommend that consideration be given to additional ways to allow the Health Care Financing Administration to take advantage of the market structure, to price things competitively, for example.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I was glad to hear what you said, Dr. Van de Water, with his question about column one. I think that is pretty accurate, you said, the return ratio on that chart.

Dr. VAN DE WATER. From what we can tell, yes, sir.

Senator GRASSLEY. All right. I am glad to hear that, because in 1992, when I introduced legislation to give more money, or in a sense to take part of the Inspector General's budget off the budget so they could put more into this effort, we got word from CBO that it could not be scored. I think you are saying now that it can be scored, is that right?

Dr. VAN DE WATER. I am not sure what "it" is. Unfortunately, the details do make a difference. Again, we are pursuing a proposal

along the lines that Senator Packwood raised, in which one sets up a permanent appropriation that increases the amount of real resources. That looks like a promising approach. If we were merely expanding the existing discretionary appropriations, the Budget Act scorekeeping rules would set up some bars.

Senator GRASSLEY. Well, "it," as far as I was using the word, would be additional money off budget for this effort. I do not know whether that was what the Chairman was speaking of.

The CHAIRMAN. I was not thinking on or off budget so much as a dedicated fund if the CBO would score it.

Senator GRASSLEY. But something more than what they have got right now.

The CHAIRMAN. Something that gives them some guarantee that, year after year, they will have money to pursue fraud and abuse without having to come to the Appropriations Committee each year and hope that they will get it.

Senator GRASSLEY. Within his definition then, can you score that, and do you find it a little easier to score now than in 1992? I do not know whether we were dealing with you or somebody else in CBO, but whoever we were dealing with said it could not be scored.

Dr. VAN DE WATER. Although I was not in my current position then, we do try to be consistent and not give you different answers at different times. But I am also trying to leave myself a little leeway because, as I said earlier, all of these matters depend on the precise details of the legislation.

But we do believe that the approach that Senator Packwood has outlined seems promising, and we would be eager to work with your staff and the committee's staff to see if something could be developed along those lines.

Senator GRASSLEY. Also, I appreciate what you said about fraud. I think that we have to be careful that we do not lead the public to believe that taking care of the fraud situation is going to solve our Medicare problems, because I do not believe it is going to.

What would you say to those in the general public who think that we can do that, and especially to the baby boom generation, I think, where they are most concerned about it, the extent to which we can solve the Medicare problem by attacking waste, fraud, and abuse, Dr. Van de Water?

Dr. VAN DE WATER. I would certainly say that attacking fraud can make an important contribution. But when you are getting into larger numbers of the sort that are currently required to maintain Medicare on a sound basis, you are going beyond things that could be narrowly viewed as fraud and into these softer areas of abuse and waste.

As I was preparing for this testimony, I read previous statements by some of today's witnesses, and I was struck by something that the Inspector General said a few weeks ago to another committee, relating to her comments about program audits and evaluations. She pointed out that substantial savings require making major structural changes in the program.

I would quote two sentences: "Legislation is required to make structural changes, and it is these changes that result in large savings. The Social Security Act, in many ways, is so prescriptive in how Medicare processes claims, what services are covered, and how

reimbursement rates are determined, that legislation is required for most of our recommendations." I hope I have not taken that too much out of context.

Senator GRASSLEY. Well, I think what you are describing here is better management as opposed to just the fraudulent use of taxpayers' money today in correcting that problem.

Dr. VAN DE WATER. Even more than better management, it is structuring the program to make it easier for the managers to do a good job. What I believe the Inspector General is saying—and perhaps she would care to comment—is that the structure of the program itself makes the task more difficult. I think Ms. Jaggar was saying the same thing as well.

Senator GRASSLEY. Could I ask one more question?

The CHAIRMAN. Go ahead.

Senator GRASSLEY. Mr. Owens, when Director Freeh was before the Aging Committee he talked some about organized criminal activity in the health care system. From your perspective, could you tell us what kinds of groups are committing such crimes and how organized they are?

And are we talking about criminal syndicates which have been active in other areas of criminal work and are now branching out into health care, and are there particular tools you need to deal with this type of organized crime as opposed to organized crime in some other area of the economy?

Mr. OWENS. I would say we are actually talking about two types of groups that are involved. One, is the group that becomes aware of the nature of the health care system and how it operates and attempts to take advantage of it. For instance, there is one matter in particular that I am aware of where a group came in and established an ambulatory service because they knew that they could take advantage of the system there and reap tremendous benefits by operating that and defrauding the system.

The other type of group we are talking about is a group that I think would meet the definition of an enterprise under the RICO statute, and we have indicated in our written remarks that we think it would be appropriate to have any new health care fraud offense as a predicate for RICO.

What we are talking about here is an enterprise, an existing organization, which again turns toward a pattern of criminal activity to carry on their business. So this could be an organization that, for all practical purposes, starts out as a legitimate health care provider and, because of the nature of the system or for whatever reason, they turn to committing a pattern of fraud. So I think we really have both groups involved in the industry.

Senator GRASSLEY. Are these people with a background already in criminal activity somewhere else in the economy, or are these brand-new people?

Mr. OWENS. In my first example, the one case in particular I am aware of—I used to be in our Atlanta field office—that was absolutely the case. In fact, one of the individuals had a criminal record previously, yes.

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. I want to thank you for holding this hearing. This has been a matter of interest to me

since we held hearings back in 1991 in the Senate Budget Committee and found a real pattern of abuse in the Medicare program.

In fact, I held a hearing in North Dakota in 1991 and during the hearing a woman stood up from the crowd who was a medical equipment supplier in the State of North Dakota and described a kick-back scheme that she had been asked to participate in by a company from out east.

In this kick-back scheme, wound kits were to be sold for $40, that are worth about $4 apiece. They were to be sold for $40, or at least that is what Medicare would be billed, and she would get a kick-back of $9 for every wound kit that was sold. This woman just stood up in the audience and offered this as an example of what she was subjected to.

We heard a lot of remarkable testimony in those three hearings we had before the Budget Committee in 1991 about every kind of scam imaginable. I also had it brought to my attention by a constituent back home who had an elderly mother in Florida. She returned to North Dakota after the winter, yet they kept receiving notifications of billings to Medicare by a doctor who was supposedly visiting the mother every month in the nursing home and billing Medicare. It went on for a year.

Now, this is a doctor that was really remarkable to be able to extend that kind of coverage to a woman who was in North Dakota, visiting the nursing home in Florida and having a chance to examine her. Repeatedly, what we found and what we heard were examples of abuse, double billing, every kind of scam imaginable.

I would be interested to know from this panel, especially Dr. Van de Water, is it your impression that things have improved since that time or have things pretty much stayed the same? What is your sense of where we are with respect to fraud in the Medicare system?

Dr. VAN DE WATER. Senator, I do not think I am the best person to attempt to answer that question. We rely on the people in the field, and I think they would be in a better position to characterize that than I would.

Senator CONRAD. Let me just ask any of the members of the panel what their impressions are. Have things improved, are they pretty much the same? What is the level of abuse that is going on, in your judgment?

Mr. OWENS. Well, I am not sure I can assess whether or not there is improvement, but I can certainly tell you, from our standpoint, that our case load has improved tremendously, both as it applies to the Medicare and Medicaid programs, and also the private insurers.

The CHAIRMAN. Has improved?

Mr. OWENS. Has increased substantially. We really see no subsiding in that. We are hopeful that some of these major settlements that have been achieved in applying civil penalties and other things can begin to have some deterrent effect and such things as Congress taking a more active role in attempting to address the problem, and possibly passing a specific health care offense will have that effect. But I do not think we are in any position right now to determine if there is improvement or not, frankly.

Ms. BROWN. If I might answer, too, I think there is definitely an increase in the amount of fraud going on, just as there is an increase in the amount of money being spent in this area. We are fighting a battle, but we are not keeping up with the increases.

Senator CONRAD. You know, we had really stunning kinds of testimony at that set of Budget Committee hearings. Let me just give you one of the examples that was one of the most outrageous. This was a billing for four boxes—four boxes—of ostomy sleeves, which cost the client $129.40.

Those sleeves have three parts: the sleeve, a plastic ring, and a clasp. They are not useful separately, they have got to be used together. A supply company billed Medicare $1,500 for the sleeves, $800 for the plastic rings, and an additional charge for the clamps, to total $2,300 for $129 of supplies.

I mean, it is crookedness on such a grand scale that it is breathtaking. I mean, who sits around and conjures up these schemes? You really have to wonder what kind of people they are.

A nursing home subsidiary supply company, which bought catheter straps in bulk for 78 cents apiece and sold them to the parent company for $2.85, which then sold them back to the nursing home for $8. Now, that is a real money-making deal. You get them for 78 cents, you sell them to the parent company for $2.85, and then sell them back to the nursing home for $8. That is a 10-fold increase. This has threaded its way through the system. You really have to wonder how deep this is.

Ms. Jaggar, you wanted to comment.

Ms. JAGGAR. Senator Conrad, I think, in looking at the increase or the wider distribution of fraud and abuse, an important factor to consider is that the health industry today has diversified and is increasingly moving toward more provision of care in less formal settings, more home health care, more nursing home care. There are many, many more participants in the health industry now than there were when you and I were young.

Then most care was provided through hospitals and it was an environment which was an easier one in which to have some controls. Now there are so many more participants, as Ms. Brown says. The industry itself has grown dramatically and it makes it much more difficult to put controls on the industry that will assure that the kinds of abuses that you are discussing do not occur.

Ms. BROWN. Senator Conrad, if I might add, we too have testified in the past about a couple of things that HCFA needs. One theirs is an inherent reasonableness standard which would allow HCFA to change the dollar amount reimbursed for an item when there is proof that the item could be bought on the open market at a much lesser cost.

Right now, in order to change a reimbursement amount, HCFA must go through a very cumbersome procedure that takes 2–3 years. So even where we find things like a glucose monitor, for example, where HCFA was paying $200 per monitor, individuals could go to any drugstore and buy them at $50, plus get a coupon for a rebate for most or all of their out-of-pocket expenses.

It took HCFA between 2–3 years to change the price they were paying for glucose monitors, and by then they had gone down even more. HCFA also needs the ability to competitively bid, as VA does

and as the private sector does. Thus, products for which they have a known amount of usage, HCFA could competitively bid and get the best price the market has to offer.

As long as HCFA has a set amount that it pays regardless, there will be unscrupulous people that substitute inferior merchandise or take advantage of something that happens to be at an inflated point in its sale trend. We must remember that prices do change over a period of time, depending upon the volume of usage.

Senator CONRAD. Well, I appreciate that.

The CHAIRMAN. I think, Ms. Jaggar, what you meant was when Senator Conrad was young. You have not crossed that threshold yet.

Ms. JAGGAR. Thank you.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I want to ask a question about a statute that I sponsored in 1986, and I call it one thing and lawyers call it another, so let me describe it. It can be called the False Claims Act. That is what I call it. Lawyers sometimes refer to it as qui tam, but basically it gives an individual, if he knows about fraudulent use of taxpayers' money, to sue in place of U.S. prosecutors doing the suing.

Since this was amended in 1986, nearly $1 billion has been recovered under provisions of this legislation. I think that there has been nearly 200 of these actions in the health care fraud area. Many of these have exposed significant fraud, the most significant was the California case that recovered $110 million.

So I, first, would like to ask how important qui tam actions are in the overall effort against health care fraud, more specifically given that Federal resources are always going to be limited. Can these types of actions not help make up for insufficient Federal resources in an effort against health care fraud?

Also, let me say one of the reasons I might be asking your expert testimony in this area is whether it is from the defense industry, or now I am hearing in some instances from the health care industry, there are always efforts being made to repeal this legislation that has brought in $1 billion to the Federal Treasury.

I suppose it is most appropriate for you, Mr. Owens, but if anybody else wants to comment. Maybe even Ms. Brown would be a good one to comment as well.

Mr. OWENS. Well, from our perspective it has been a very valuable piece of legislation. Traditionally, the FBI, as the primary criminal investigative agency within the Department of Justice, focused almost exclusively on criminal matters.

The qui tam suits that have been filed have generated much additional work for us, and we have worked with the department and we are, in an increasing posture, addressing more and more of these type matters from a civil perspective.

We have also found, however, that in looking into those matters when the allegations come forward, many times they serve as a predicate for criminal investigations, which we will then launch into, too. So from my perspective, it has been extremely helpful and we intend to continue to work on those.

Senator GRASSLEY. Anybody else want to comment?

Ms. BROWN. Yes, I if I may comment. We, too, feel it is extremely valuable legislation. We currently have 75 qui tam cases under way and we have collected over a quarter of a billion dollars, which you mentioned, in our cases. So, we certainly support that legislation.

I might comment though, you mentioned the fact that qui tam cases are a help with resources. Qui tam cases also demonstrate our lack of resources. When we get these allegations, they need to be investigated, and my organization does that investigation.

As Mr. Owens mentioned, the FBI concentrates its efforts on the criminal side, not the civil side, where we do both. So this lack of resources, and not having an OIG presence in 24 States, also interferes with our ability to follow up on qui tams that we otherwise might be able to follow-up on.

Senator GRASSLEY. My last question would be this, Mr. Chairman. Mr. Owens, we hear about fraud in the electronic processing for income tax returns. Of course, Medicare claims are increasingly being electronically submitted, I understand. To what extent do we see fraud in the electronically-billed claims, and is this presenting special legal problems for law enforcement?

Mr. OWENS. I am not sure I can give you an assessment of the extent of the fraud in that manner. Certainly if that is a major problem, we would attempt to address it. We could address it, we could reach it, through the Federal Fraud By Wire statute, but I am not aware of the extent of the fraud. We certainly can look into that, if you would like.

Senator GRASSLEY. Well, you would be aware of it if it is a problem, I could assume, right?

Mr. OWENS. Someone on my staff would be. We could evaluate our cases and the allegations we received.

Senator GRASSLEY. Ms. Jaggar?

Ms. JAGGAR. Senator Grassley, the Health Care Financing Administration is working at this time on developing a new system called MTS, the Medicare Transaction System. The objective of that system, which is several years until it goes active and online, is to help pull together the diverse processing that occurs with 72 different contractors around the country. Medicare right now processes about 800 million claims a year.

One of the objectives, an important objective behind that system, is to have a consolidated place so that they can do comparisons across different parts of the country and identify the occurrence of electronic fraud or other kinds of fraud more easily. So it is an area that they are concerned about, but I have not heard any numbers that indicate the prevalence of it.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman. I will forego this round because I see we have a colleague here. I think we would like to have a chance to hear from him.

The CHAIRMAN. We want to quiz him extensively, too.

Senator CONRAD. Yes.

The CHAIRMAN. Thank you, folks, very much for coming this morning. We appreciate it.

Now we have Senator Cohen with us, who has done yeoman work. I think you are the first one that, at least forcibly, brought

this issue to my attention. I think we had had other reports, but it is not quite the same as a colleague grabbing you by the shoulders and saying, listen. I want to congratulate you on what you have done.

STATEMENT OF HON. WILLIAM S. COHEN, A U.S. SENATOR FROM THE STATE OF MAINE

Senator COHEN. Thank you very much, Mr. Chairman, and members of the committee. First of all, let me thank you for allowing me the chance to address the committee this morning on the subject of how fraud and abuse is really driving up the cost of health care for all Americans.

As the Chairman of the Aging Committee, on which Senator Grassley serves as well, I have directed the staff to investigate the explosion of fraud cases throughout the health care system, and particularly those pertaining to Medicare and Medicaid.

This has been a high priority for the Aging Committee for the past several years because we have been advised by the Justice Department, by the Health and Human Services Department, and also by GAO, that we are losing roughly 10 percent of all money expended on health care in this country to fraud and abuse. That translates roughly into as much as $100 billion a year.

Out of the Medicare/Medicaid programs, that works out to about $27 billion. If you include all of the Federal programs, Champus and other types of veterans' programs, it works out to about $40 billion annually that we are losing directly through fraud and abuse. I think what is so dramatic is how shockingly easy it is to defraud the health care system.

Mr. Chairman, you mentioned that I am the one who has grabbed you by the scruff of the neck, so to speak, and tried to shake the Senate into an awareness of this problem.

It did not start with me, it goes back to a mutual friend of ours, Jack Heinz, who in fact was killed in a helicopter crash while on his way to a hearing in Pennsylvania to investigate the so called durable medical equipment scams that were flooding the health care system at that time. So the effort has been under way for a good period of time to look at fraud and abuse in our health care system.

As a matter of fact, I recall back in 1981 we had a hearing in which we called some expert witnesses. There was one particular expert witness that we called that remains vivid in my mind. He had impeccable credentials. He was a physician with a number of degrees. He had vast experience in the field of delivering health care. He was also a convicted felon. He had been convicted, I believe, of at least five different felonies over a period of time in several States, and we called him as an expert witness.

What he said at that time was, "I just simply could not resist it. It was so easy that I could not resist, the devil made me do it." Well, the system made him do it. He could not resist padding claims, submitting claims for phony patient lists, and for services never rendered.

One would have thought after that particular session that he had sort of rectified his ways, he had found the true path to righteousness. That was not the case.

In 1990, he was admitted to practice medicine in the State of Pennsylvania. I believe it was 1991 when he opened up a diet clinic, or something of that sort. Then he proceeded once again to defraud the Federal Government of millions of dollars.

Just this past spring, he was sentenced to serve, I believe, about 7 years in prison and was fined several million dollars as a result of his fraudulent activities. So he simply found it irresistible again. It is too easy, and that has been the problem that we have looked at over the years.

One of the difficulties we have—and I was unable to hear the testimony of the witnesses preceding me—is that our health care enforcers are dancing and paying as fast as they can. They are processing about four billion claims every year.

If you look at the amount of manpower, if I can use that phrase in this circumstance, or womanpower, but basically enforcement power, the FBI, as I recall their testimony in a hearing that the Aging Committee held, the FBI Director indicated that there were roughly 258 FTEs—Full Time Equivalents—working on health care fraud. If you count the Inspector General's Office and HHS, I think there are another 228, maybe another 230 individuals.

But essentially you have less than 500 people in the Federal establishments that are directly involved in overseeing the health care system looking for fraud and abuse. Given the numbers of dollars that are being spent, you can see that it is almost impossible to have a really tough, enforceable system, given the numbers that are involved in overseeing it.

So what you have, in essence, is a system that is poor on the prevention side, weak on the enforcement side, with very big dollars involved.

What we have found on the Government Affairs Committee, as well as virtually every other committee that we serve on, is that whenever you have large amounts of money and you have very little chance of being caught, very little chance if you are caught of being prosecuted, very little chance of being convicted if you are prosecuted, and very little chance of going to jail for any length of time if you are successfully prosecuted, then you are bound to attract a very strong criminal element which is what has happened to health care as well.

One of the more disturbing trends that was testified to by Louis Freeh, the Director of the FBI, is that organized crime has now moved into health care in a very major way. We have perpetrators who range from international crime rings, fake unions, networks of doctors, specialists, attorneys, to professional patients who are ginning up phony medical diagnoses.

One of the things that was going on in the west coast were rolling labs in which the labs would send out a notice; we have a deal for you, we are going to give you some free medical tests, some blood tests, and we will evaluate whether or not you have any potential diseases.

Of course, the people come in, they fill out the forms, they take down their medical history, and then these particular rolling labs start to submit a phony list to Medicare, Medicaid, or the private payor systems of all sorts of ailments that are, in fact, not

true.They just simply list them on a sheet and get reimbursement for them.

Then those innocent patients find themselves either responding to insurance claims listing that they have fatal diseases, which they do not, or they may even, in fact, be led to believe that they are completely healthy, because these tests are never really conducted. They go nowhere. But you have these submissions of lists to the medical insurers for payment, which are completely fabricated.

So it works both ways. On the one hand, people who have had the test feel that they have been checked out, falsely in this particular case, and those who are, in fact, being checked out have a list of ailments which they do not have, and those are submitted for reimbursement to the insurers. This has been going on a wide scale. We have had testimony to that effect.

I think Senator Grassley was there during the course of testimony whereby some organized crime elements in New York had moved in and targeted the Russian emigre community. They will offer, for example, angora undergarments to the Russian emigres. It may not sound very attractive to us, but it is a very big item back in Moscow, St. Petersburg, and other places.

They will give these items to the Russian emigres, get their Medicare or Medicaid card numbers in return, then start billing for all sorts of services and goods that were never delivered to the particular patients, to the tune of millions of dollars. This has been going on on a very wide scale.

The CHAIRMAN. I thought you were going to say the angora undergarments had some health value.

Senator COHEN. Well, no. They do not have any health value I can speak of. They may be soothing to the mind, but I am not sure exactly what their attraction is. They are an attractive item to a certain group. That is just one of the scams being run.

I could spend the morning describing for you the types of things that have taken place in the field of durable medical equipment. We have examples of a piece of pink foam that may have cost a few dollars to produce. It was billed to Medicare as a flotation mattress for $1,100; a piece of foam that was virtually worthless.

We have had cases of seat pads, such as we might put here, billed as some sort of medical pad for wheelchairs at $300 and $400 each, even though they might retail for $25.

We have examples of what they call unbundling, where you might have someone who is a diabetic who has to have a daily shot of insulin, and they can, in fact, turn to the local Washington Post or any other paper in the country and they will see a kit that is advertised for, let us say $40 but with the manufacturer's rebate it works out to $10 or $12 for the entire kit. Well, what happens is, those who are submitting these for patients unbundle the items so that each individual item in the kit is billed separately and the total will go well over $150 or $200. This is going on on a very significant basis as well. We also have unbundling with respect to wheelchairs or other pieces of equipment that are supplied, billing for each individual item so that the sum total, of course, is quite excessive.

I would say that most of the health care providers, obviously, are professionals and they are honest and they have the best interests of the patients in mind. But we have far too many who have learned how to manipulate the system and to serve their own financial interests through this fraud.

We have, for example, a number of multi-million fraud settlements that have been negotiated with major clinical labs, hospitals, home care companies, and we have a number of health care providers currently under investigation by the Inspector General, and also by the Justice Department.

Again, the abuses are so shocking to the taxpayer. One home health care company has been charged with billing the Medicare program for, among other things, $85,000 in gourmet popcorn given to physicians as promotional items. We have had other abuses involving padding claims and cost reports to Medicare, charging the government and beneficiaries outrageous prices for those unbundled services, billing for costs that have nothing to do with patient care. We have clinics that bill for phantom patients. We have lists that are submitted for patients that do not exist. We have double billing, triple billing. We have upcoding, billing for either an item or a service well above what was provided. Again, I could take most of the morning to talk about this, but I think you have a pretty good comprehension of the kinds of abuses that are taking place.

Earlier this year I introduce S. 245, which was the Health Care Fraud Prevention Act, which is designed to enhance the penalties and the resources available for anti-fraud activities. Senators Dole, Simpson, Nickles, and other members of this committee were cosponsors. It is truly a nonpartisan issue. This is something that should, and has, attracted support from Democrats, as well as Republicans.

Two months ago, the Senate voted 99–0 in favor of a budget resolution amendment that I offered that stated we should give high priority to identifying, eliminating, and trying to recover funds from health care fraud.

Since I introduce S. 245 in January, I have really tried to work with all of the groups who are involved in this, all of the health care providers, law enforcement agencies, to try to strike a balance. The health care industry itself is concerned that this is going to be too tough, that this is legislation which is designed to make criminals out of innocent mistakes, which is not the objective of the legislation.

What we are trying to do is get at those consistent patterns of abuse which amount to a fraudulent exploitation of the system, but also to clarify, to make sure that we have the right kind of balance so that we do not overload the enforcement side so much that we do, in fact, criminalize innocent behavior. I have worked with these groups to make some changes.

As a result, last week I introduced a revised version of the legislation which would establish an anti-fraud and abuse program, again, that would help coordinate the activities amongst the agencies to help prevent, detect, and prosecute health care crime.

It would toughen Federal criminal laws and enforcement tools that are currently not available to the experts in the field, the en-

forcement officials. It would increase the resources available to those who are charged with combatting fraud and abuse, and it would provide a greater range of enforcement remedies to respond to various degrees of fraudulent and abusive activity.

Again, I would like to point out that most of the provider groups are taking the initiative to combat fraud. They realize that they do not want to have a black eye caused by a few of the bad apples that are in the system. But it is not enough to have voluntary action by these groups. It is welcome and I think they are to be commended for it, but we still need tough new legislation.

I have worked with Director Freeh. The FBI is very much in support of the legislation; the Justice Department is, I also believe the White House is. This issue, unfortunately, has become caught up in politics in the past. You may recall, we debated this issue when the Crime Bill came up.

I attached certain portions of the legislation to the Crime Bill. It got over to the House, and the House Ways and Means Committee stripped out the provisions, saying, wait a minute, we should apply this to health care legislation, not to a crime bill.

Of course, we did not pass health care legislation last term, so we have no fraud provisions. As a result, what we have is roughly $100 billion being lost every year. It works out to $275 million a day, or roughly $11.5 million is lost for every single hour that is ticked off on the clock.

So this legislation, I think, is long overdue. I have tried to work with the various groups involved. I believe we have struck the right kind of balance. The Justice Department, I think, is solidly behind this. I believe this legislation would be consistent with the goals of the President, and I believe it should enjoy bipartisan support from this committee and the full Senate.

The CHAIRMAN. Bill, the panel just prior to you included the Congressional Budget Office. In terms of scoring, have you had this problem before?

Senator COHEN. It is like any other problem where we are talking about saving money. It is very difficult to score savings. One of the ironies, of course, is that the House stripped out the provisions that were in the crime bill because they wanted to use the savings to help pay for the President's health care legislation. The difficulty, of course, is that OMB or CBO really are not in a position to score this. We do know approximately, and it is hard to identify on a dollar-by-dollar basis the exact amount being lost every year, but a rough estimate is, and it is a minimal one, it is 10 percent that is being lost. Now, of that amount there is no way you can actually calculate how much you will save if you pass legislation to beef up the enforcement, which gives the FBI a Title 18 statute to work with. Right now, for example, the FBI has to rely upon mail fraud or wire fraud statutes in order to apprehend individuals who commit fraud. It is cumbersome, and it takes a lot of work.

We had one case called Operation Gold Pill, where organized groups would set up a system whereby they have people who will go to a doctor, complain of certain ailments, and get a prescription for very expensive medications.

They will take those prescriptions and, instead of getting them filled, they go to a low-level dealer on the street and sell them to that dealer for, let us say, 10 percent of the value. They get 10 percent immediate reimbursement.

That low-level con man will then go to a higher level con man, who will then redistribute the medications to another pharmacy that obviously knows they are coming from a tainted source. That pharmacy will pay a 25, or even 40 percent discount to that higher level con man. Those pills will then be repackaged and sold on the street.

Operation Gold Pill took about 500 FBI agents and State officials just to conduct that one operation, because have to rely upon a cumbersome enforcement. Many times you have some of these operations who do not use the mails, who do not use telephones, who instead do it by courier. They will send off messengers to peddle these by hand in order to avoid prosecution under the wire and mail fraud statutes. So we have a new Title 18 statute, which will have a very clear statute by which the FBI can prosecute these cases.

We still cannot calculate how much is going to be returned. I think a fair estimate is in the low billions, several billions of dollars initially. But if we are losing $40 billion a year annually just out of the Federal programs, assuming we get 10 percent, or 20 percent, or 25 percent, it can add up to some real dollars.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Rather than going at a specific number as the Chairman just did, would I be correct in assuming that we are not arguing that we can resolve the Medicare program's financial viability problems through just a simple stepped up anti-fraud program?

Senator COHEN. I think it is a fair statement. I do not think we can simply say, take care of the fraud and the abuse and you have solved the Medicare problem. Obviously there are billions being lost.

To me, it is the equivalent of pouring either wood or fuel into a home to heat the home, but the home has no roof and no windows. We are allowing the heat to go up directly into the atmosphere without containing it.

So the question becomes, how much can you save by weatherizing your home, how can you have a solid roof and solid windows to prevent the escape of the heat? That is what we are looking at here. We are not going to save $47 billion or $100 billion, but we can save a great deal if we step up the law enforcement activities.

Senator GRASSLEY. But as Chairman of the Aging Committee, and you are very responsible in that position, it is then not responsible to let anybody say that anti-fraud is going to solve our problems. Even if we did that the best we could ever do it, we still have on this committee a very, very difficult job ahead of us.

Senator COHEN. Absolutely. This will not solve the deficiency in the Medicare and Medicaid funds. We are still going to have to deal with the formulas, we still have tough issues and debates coming up about how we reform the system to make it financially viable.

Senator GRASSLEY. To say it again another way, out of 535 members of Congress, I am sure we have some—I have read their statements—who want us to believe that we can solve the Medicare problem by taking care of fraud and abuse, and it cannot be done.

Senator COHEN. That is correct.

Senator GRASSLEY. Only a small percentage of it can be done.

Senator COHEN. Well, I am not sure about the percentage; it depends upon what the level of activity is. But let us start with the premise that we cannot solve the financial problems simply by curbing fraud and abuse.

Second, even though we make changes in the legislation which I think are long overdue, the fact of the matter is that criminals are ingenious. They will come up with a new way to defraud the government. Every time we take one step, they will take two. It is always going to be a catch-up process when dealing with the criminal mind. They are as creative as our best CEOs. As a matter of fact, many of them, I think, now have MBAs.

They have structured these arrangements in a way that would rival an MBA program at Harvard or Dartmouth, or any of the major schools today. So I have no doubt that as soon as we find a way to make it more difficult for them to commit fraud and abuse, they will be back with a new system and a new scam.

Senator GRASSLEY. All right. The last question. This is in regard to your bill. I think you tried to strike a very appropriate balance between strong enforcement of intentional violations and fair treatment of health care providers.

Did you encounter difficulties in distinguishing fraud from other activities that may have been abusive or questionable, but not fraud, and how did you make that distinction?

Senator COHEN. Well, I think you have to rely upon patterns.

Senator GRASSLEY. Rely upon what?

Senator COHEN. Patterns of behavior. One of the concerns on the part of the hospitals, doctors, and all those engaged in the medical profession in servicing our people is being accused of wrongdoing for an innocent mistake. Such as something that has been in correctly entered by computer into the record, we all know once it gets into a computer it is very difficult to get it out.

I continue to receive statements from the District, Virginia, and elsewhere that I should be taxed as a local citizen, and I keep having to hire an accountant each year to respond to the taxing authorities saying, I am not a resident of the area, but of the State of Maine. I cannot get it out. It has been a long time now, but it comes every year. I still have to hire the accountant ever year. That is the way, unfortunately, it works.

But if you have a computer error and it is an innocent mistake, then obviously that is something that you do not want to take any action for. But if you have a persistent pattern of over-billing, misbilling, double billing, or upcoding, then I think you can make a determination.

It is sort of like the old story. A dog knows the difference between when it is being kicked and when it is being stumbled over. I think that we also know the difference when something is done by innocent mistake or whether there is a deliberate attempt to exploit the system for financial gain.

But I think that we need to look at intent, and this is something that the Justice Department has to do. If you are talking about a criminal statute, then obviously you have to show intent.

The burden is upon the FBI, the Justice Department, and prosecutors to show a deliberate act, or one that is so willful that it amounts to an intentional act. Those are historically, I think, within our judicial system and that is what we intend to rely upon here.

If we are looking at the anti-kick back statute, for example, under the Social Security Act, again, we have a pretty strong body of case law, that the administrators pursue in looking at an intentional versus unintentional act. But I can show you the cases, and you have been on some of these cases in the Aging Committee, where there is no question it is a deliberate act of fraud against the system.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Senator Cohen, last year when we were considering health care reform and we were trying to get some sense of the numbers, and we discussed the $100 billion number, some asserted that that was an inflated number and that really fraud represented 1 percent, which would still be a very large number, $10 billion.

What is the basis for the 10 percent estimate? Do we have some strong evidence to support a number of that range?

Senator COHEN. It comes from the GAO. They have made that estimation based on just the cases that they have reviewed. If anything, I think it is probably a low figure. If you have $1 trillion involved in your health care system, if you have got just very few people overseeing this—for example, in the health care field for the Federal officials, I believe they are processing about eight million claims per individual—it is virtually impossible for anyone to pick out what is going on here.

If we look at just the cases we have handled on the Aging Committee, it is so easy to steal from the system. Senator Graham held hearings in his State several years ago, and I was reviewing the record extensively on that.

There are groups who move in, they target specific groups—it might be the Hispanic community in Florida, it may be the Russian community in New York City, or a Vietnamese community in California, wherever it might be—and they then appeal to their sense of ethnic identity and they say it is us against the system, then they start getting their Medicare or Medicaid numbers and bill the government. I mean, it is outrageous in terms of the numbers that are involved.

Now, GAO says 10 percent. I think it is probably higher, personally. I do not think it is anywhere close to one percent by virtue of the fact it is too easy. It is too easy to get away with it. Therefore, when you have big dollars and you have ease of access, to me, I think it is probably closer to almost double that figure, but that is just an estimate on my part. I say 10 percent is a conservative figure that we can rely upon.

Senator CONRAD. And when we look at what constitutes fraud and abuse, obviously I have talked about examples this morning,

as have you, that are more lurid examples of people who are out and out crooks, who are ripping of the system through, whether it is the wheelchair cushions, the wound care kits, or the floating mattress example, just egregious examples of incredible rip-offs.

But also in the system would you not guess that a lot of basically mainstream health care providers are pushing the edge of the envelope in terms of billings that they submit to Medicare? I am talking reputable hospitals and doctors who know kind of how the system works and can push the edges of what is really reimbursable?

Senator COHEN. I think that is a fair statement. I can recall walking through an airport in Bangor, Maine recently where one of the workers at the airport came to me and complained about the kind of charges that his wife had just been billed for, where she, I think, had her toenails, or something, clipped by an expert in the field. The charge came back for several hundred dollars.

I can recall, a family member of mine had to go to the hospital for treatment, was kept in the emergency waiting room for maybe an hour, and was billed a full day for a private room. I can give you list after list of what takes place.

We have the so called wave-bys, where a physician will walk in and sort of look in the room and sort of wave to the patient, and that gets billed for an official visit. I mean, the list is pretty extensive in terms of how the system is being taken advantage of now. That is in addition to the deliberate types of fraud in terms of the exploitation of the system, yes.

Senator CONRAD. Really, exploitation of the system, I think, is a good way to characterize it. I had doctors come to me when we were in the middle of health care reform last year and give me example after example about how the system magnifies costs from doctors who are billed.

You have a situation where, in every surgical suite in America every morning, they are giving medication to those who are about to undergo surgery. You have a supervising physician and you have others who are administering the medicine directly. There is a lot of extra billing that gets done.

I mean, I have had the doctors who are involved in it tell me they think it is just all wrong, and it is part of the process. It is not seen within the system as being illegal, immoral, or wrong. It is the way the system works, and that is going to have to be addressed.

Senator COHEN. Could I just respond and perhaps lead into Senator Graham, who held hearings in Southern Florida a couple of years ago. As I recall, there was a woman who testified during the course of that hearing about her mother—or maybe it was her grandmother, Senator Graham—who was in a nursing home. She was quite elderly, in her late 80's, as I recall, was almost deaf and could not hear virtually anything.

Yet, each day she would be taken into a common room and a psychiatrist would come into the room and offer some words, which she could not hear. It would not have made a difference, anyway. Her mind was fine, she just was almost stone deaf.

Yet the psychiatrist came in, offered some words, and it was billed as a psychiatric evaluation, or consultation, or therapeutic

treatment, even though she had no idea who he was, what he said, and it was of no benefit whatsoever.

The woman's daughter complained and it finally was stopped for a time. Then it was started again. Finally, she complained again and the woman was no longer included in the group sessions.

Nonetheless, the psychiatrist was brought into a group session where there were 40 or 50 people, in which he would then bill for each of the 50 people for the session that day, even though it may not have been necessary for any kind of psychiatric counseling at that time. So, yes, it goes on.

You have billings that, I think, are probably necessary for the hospital or the nursing home in order to stay in business. They need to have so much revenue coming in, so the revenue tends to expand to match their requirements and it may have no relation to the need for the service.

I will give you one other example of the kind of abuse I am talking about. We had a lady in a boarding home in Maine. She fell and she received a scratch on her arm. I think it was less than an inch, about three-quarters of an inch. It was not deep enough to warrant surgical attention. A local supplier of medical goods shipped up some 6 x 8 waterproof bandages, and she used, I think, about 14 of them. Perhaps they might have retailed at $3 or $4 each, but in any event it probably should have amounted to no more than $40 or $50. Had the owner or manager of the boarding home gone down to the local drugstore, it would probably have been a tenth of that, or half of that price.

Do you have any idea what, ultimately, we were billed for that little scratch? It worked out to about $3,400 in terms of the amounts of dressings that were sent to that boarding home, plus packages of gels that probably would have helped to service the Persian Gulf military needs at that time. But, nonetheless, it works out to about $3,400, as I recall, just for that one scratch.

Senator CONRAD. Could I just say in conclusion, Mr. Chairman, for those who were arguing last year that the amount of abuse in the system is less than $100 billion, I just want to be on the record with Senator Cohen, I believe it is more.

When one takes these conscious fraudulent activities and then marries them to the way the system is operating, the incentives that are in the system for otherwise responsible institutions, medical professionals, there is an enormous incentive to inflate these costs, and everybody in the system knows it.

I have had dear friends in the medical profession tell me that it is a scandal. They do not like being part of it, but it is the system, and we have got to do something to change it.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I want to commend you for inviting our colleague, Senator Cohen, to join us today. There is nobody who has worked harder on this issue of ferreting out fraud in our health care system, and that particularly affects the elderly. I am a great admirer of his efforts.

Mr. Chairman, I would like to make a point again today that I have made in the past, and that is, again, we have an indication of the importance of moving from theory to specific.

I am very pleased that Senator Cohen has given us legislation which we can use as the basis of serious legislative consideration for what we need to do in order to suppress fraud within the Medicare system and make that degree of contribution towards meeting the $270 billion goal that we have for reducing the overall expenditures of the Medicare system in the next 7 years.

If I could cite another area which is a close cousin of the story that Senator Cohen has been telling us, and that is in the area of managed care. Yesterday's Miami Herald ran a very interesting opinion article by an emergency room physician, which I would like to ask be entered into the record after these remarks.

In that article the author, Dr. Paul R. Lindeman, stated "Managed care health plans typically limit choice of doctors and hospitals and attempt to closely monitor services provided. Their goal is to curb unnecessary tests and hospitalizations to keep costs down. In the case of for-profit managed care companies, the additional purpose is obvious.

But what happens when managed care meets the emergency room? Federal law requires a screening exam at emergency facilities, but HMOs are not required to pay. By exploiting this fact, managed care is able to shift costs onto hospitals, doctors, and policyholders, thereby "saving money."

Dr. Lindeman then goes on to cite a number of specific examples, and I would just mention one. "Consider now a 60-year-old female who arrives at the emergency room complaining of chest pain. The triage nurse examines the patient, obtaining a brief history and vital signs.

"A call is placed to the insurance company and a recorded message is obtained without specific instructions regarding emergencies. The patient is treated, but the payment is denied. Reason: authorization was never obtained."

That is a form of fraud on the system which does not end up costing Medicare, but it ends up costing the patient, who will now be responsible for this bill, or costing in a denial of important medical services.

Again, Mr. Chairman, I think this underscores the fact that we need to move as quickly as possible to a specific proposal of how we are going to reach the $270 billion of reduction in this program over the next 7 years so that we can look with close attention to, what can we do to suppress fraud to the maximum, what can we do to assure that a new form of fraud does not leak over into our efforts to increase the number of older Americans who are covered by managed care programs.

So, again, I would hope that as soon as possible we would be able to have those kind of detailed hearings and all of the participants in this system will be better served the more quickly we can come to that specific set of detailed considerations.

With that opening, I would like to say that one of the areas that has concerned me greatly is the issue of, how do we prevent Medicare fraud? Our current efforts have been described as pay-and-chase. We pay bills and then try to chase down to determine if there were examples of fraudulent behavior. We do not do very much to try to prevent paying the bills in the first place.

The key to the Federal Treasury is a provider number. Once you have a Medicare provider number, you are then entitled to submit bills and it becomes much more difficult to determine fraud after you have let a fraudulent entity get that key to your system.

I spent a day earlier this year at the U.S. Attorney's Office in South Florida working on a specific Medicare fraud case, where, in brief, a group of fraudulent persons used, without authorization, the names and fraudulent signatures of physicians to apply to Medicare for a license to operate a medical clinic.

The address that they used was a mail drop. No one went to inspect to see if, in fact, the address was a credible medical facility. They billed Medicare, in less than 9 months, $550,000, all fraudulent claims. Then they left, and Medicare is trying to chase them down.

If we had been as serious about giving the provider number as a credit card company is in giving you a personal credit card with a $1,000 limit, they would have never gotten their provider number in the first place. That is illustrative of how porous the current system is.

So let me ask a question, Senator. Having studied this issue extensively, what do you think would be required in terms of expenditures, from auditors, to investigators, to prosecutors, to all of the components of an effective fraud suppression system, in order to do an optimal job of suppressing Medicare fraud?

Senator COHEN. Well, first, let me respond to your statement about, if we had as much difficulty getting a provider number as one does a credit card. I think that probably is not a good example. I think it is pretty easy to get a credit card with a $1,000 balance by virtually anyone that applies for it.

But the point you highlight is one that has plagued the system in past years, and to this day, apparently even in Florida where you have just visited, continues. What needs to be done is greater care given to allowing those into the system, as you suggested.

HCFA, or the Health Care Financing Administration, has, in fact, tightened up considerably. Several years ago, I even applied for a medical provider number myself through Portland and was about to get it, and I decided that I did not want to exploit the system myself and just held off on it.

But it was just as easy for me to get a provider number by saying, XYZ Company, operating out of Portland, Maine, and I want to supply durable medical equipment. I was on the verge of getting one, just like that. Of course, I could have then exploited it by putting a list of patients who did not exist, or having their numbers available, and then billed the Federal Government for the services never rendered.

I do not think anyone can tell you, with any specificity, what it is going to cost to put together a really tight, well-run health care system with the kind of enforcement mechanisms we need.

What this legislation does, however, is it allows funds to go into an account. As the FBI and the Justice Department start to crack down on the major institutional organized types of criminal activities, those penalties are going to be going into an account which can then be used to hire more enforcement officials, more FBI agents, more FTEs in the IG's office. That was the subject of some

criticism because it looked as if, well, gee, we have got a nice bounty hunting system now.

We have all of these groups who are going to go after innocent people and hospitals who simply have billed up that kitty so they can hire more and more people, and suddenly you have got a giant amoeba that has been formed that started out small and has gotten big and we have an overbearing criminal prosecution system.

What the legislation would provide is that the monies that are, in fact, collected from the prosecution, or the restitution should there be civil penalties imposed, go into an account, but that account has to go through the appropriations process so that there is Congressional control over what will be spent during the course of a year.

But I do not think I am in a position to tell you how many hundreds of millions of dollars have to be spent in order to pick up the $40 billion that we are currently losing. That would be something that perhaps OMB or GAO might be in a better position to do. I really am not in that kind of position.

Senator GRAHAM. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Conrad.

Senator CONRAD. No. I just want to thank Senator Cohen for the work that he has done in this area. I think it is valuable and I think it is important. I think not only is the Federal Government getting ripped off, but other insurance companies are getting ripped off, individuals, companies. It is very widespread and it is something that we need to make every effort to change.

The CHAIRMAN. Bill, thank you very much for first-rate work. I personally appreciate it and hope we can adopt some of it.

Senator COHEN. Could I just offer one final comment?

The CHAIRMAN. Yes.

Senator COHEN. I think we have to come back to the premise that most of the people in our health care providing system are honest, and they are professional, and they want to give the best care possible to their patients. The difficulty is, you have got a small group of people, on the one hand, who are the real hard-core criminal types and you have the system itself, which Senator Conrad has pointed to, which lends itself to abuse.

I am not sure we can ever devise a health care system that we can afford unless we deal with something called wellness, unless we start adopting better health care habits for ourselves. Right now we tend to look at the outcome.

Look what we pour into our health care system. We pour in people who do more damage to themselves than perhaps any other system. We drink too much, smoke too much, we eat too much, we do not exercise enough, and then we become sick or ill and we spend millions of dollars to get well again. We really do have to adopt a wellness ethic for most of our society.

Look at the demographics and what is taking place with the aging in this country. We have got to take better care of ourselves up front. There will always be those who will need additional care, either by genetic predisposition or through some accident or illness. But unless we start to take better care of ourselves and look after ourselves, we will never be able to afford a health care system in this country.

The CHAIRMAN. When Doctor Sullivan was Secretary of Health and Human Services, he said the same thing at least three or four times before this committee. The quantity of money that is savable with just the four factors you mentioned is probably beyond anything we are likely to pick up on fraud, or anything we are likely to pick up on some kind of a priority list of things for which we will not pay.

Senator COHEN. Mr. Chairman, about two or three weeks ago we had another hearing in the Aging Committee which I think should be of interest to this committee as well. We had some of the country's foremost experts testify on brain disorders and diseases. The testimony was virtually unanimous, that if you could delay the onset of Alzheimer's, Parkinson's, or stroke, for 5 years in those three categories, you will save roughly $75 billion a year in our health care system.

So it comes down to the question of priorities, again. Do you put a little more money up front into research and development where most experts feel we are really on the edge of breakthroughs? Or do you say we cannot afford it this year and the budget is going to require us to reduce down some $270 billion, whatever the figure is going to be, and therefore, at the far end, you are going to continue to have the additional $75 billion a year that could be prevented? Those are the kinds of choices we have to face up to.

The CHAIRMAN. Thank you, Bill, very much.

Senator COHEN. Thank you, Mr. Chairman.

Senator GRAHAM. Mr. Chairman, if I could just add one comment to that excellent concluding remark about the importance of wellness. I hope that when we do get down to dealing with the details of Medicare reform that it will have a significant emphasis on exactly that point, issues of what kind of early intervention should we be doing, not dissimilar with what we are doing now with Social Security, where we are letting people know several years before they reach retirement what their economic well-being is.

Maybe Medicare ought to consider some early knowledge and intervention before people get to be 65 to assist them in reaching 65 in the best possible state of health, so as to avoid some of those avoidable medical expenses after 65.

I think that ought to be an important part of our Medicare reform proposal and I, again, would hope that it would be something that we would have a chance to look at as quickly as possible so that we could shape a wellness component of this effort that would be as effective as possible.

Senator COHEN. A very good point, Senator. I agree.

The CHAIRMAN. Thank you.

Senator COHEN. Thank you, Mr. Chairman.

[The prepared statement of Senator Cohen appears in the appendix.]

The CHAIRMAN. We are adjourned.

[Whereupon, at 11:21 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF JUNE GIBBS BROWN

Good morning, Mr.Chairman and members of the Committee. I am June Gibbs Brown, Inspector General of the United States Department of Health and Human Services. Thank you for giving us the opportunity to testify on the subject of health care fraud and abuse, and what we are doing to address it.

As members of the Senate Finance Committee, I know that you appreciate the seriousness and complexity of health care fraud and abuse - a growing problem which continues to squander and deplete our limited Governmental resources and adversely affects each and every American taxpayer, as well as our program beneficiaries. As Congress considers various changes to health care delivery and financing, it is appropriate that the dialogue also focus on those savings that can be achieved through aggressive efforts to reduce fraud, waste and abuse. If our Medicare and Medicaid programs are to continue serving our elderly and needy in a comprehensive and cost effective manner, then it is imperative that we marshall reasonable resources for fighting greed, corruption, and outright illegal activities in these programs. Investigating and prosecuting health care fraud makes good budget sense. As we will later explain, the OIG's efforts in these cases generates a return to the Treasury of at least $7 for every $1 spent in health care fraud investigatory activities.

Mr. Chairman, this Committee has long been on the forefront in the ongoing battle against fraud, waste, and abuse in the Medicare and Medicaid programs. Along with the Aging, Governmental Affairs, and Labor and Human Resources Committees, the Senate Finance Committee has assisted and supported the mission undertaken by the Office of Inspector General (OIG), through its 920 auditors, investigators, and inspectors nationwide, to identify and remedy health care fraud, waste,

and abuse. Mr. Chairman, your co-sponsorship of the Medicare and Medicaid Patient and Program Protection Act of 1987 (Pub. L. 100-93) was instrumental in the enactment of many of the civil administrative remedies currently provided to us for sanctioning aberrant health care providers and practitioners. In 1987, you stated that the OIG should be provided, "with sufficient authority to better protect the beneficiaries of the Government health programs and the taxpayers' investment in those programs." Mr. Chairman, you also stated that:

> "It's time we took action to remedy these problems. When fraud and financial abuse occur in Government health care programs, American taxpayers are the victim. In the case of inappropriate or inadequate care, the real victim is the patient. This cannot be tolerated."

Cong. Rec. S. 10537 (July 23, 1987).

As a result of the Congressional enhancement of our civil monetary penalty and exclusion authorities in 1987, the number of fraudulent and abusive providers sanctioned by the OIG has increased dramatically. For example, in FY 1987, we imposed 440 administrative sanctions against individuals and entities that defrauded or abused the Department's programs and/or its beneficiaries. In 1994, we imposed 1334 such sanctions, an increase of over 300 percent. From 1983 to date, our office has excluded over 9,000 health care providers and practitioners from participation in the Medicare and Medicaid programs. Only about 25 of these 9,000 exclusions have been overturned in the administrative and judicial review process.

Despite our efforts, it is clear that further action must be undertaken to address the increasing incidence of health care fraud and abuse. Now is the time to implement new legal remedies and

reverse the downward trend of funding for efforts to combat health care fraud and abuse.

OVERVIEW - THE OFFICE OF INSPECTOR GENERAL

By way of background, the OIG was established in 1976, and is statutorily charged with protecting the integrity of Departmental programs, as well as promoting their economy, efficiency, and effectiveness. Through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department, and to protect its programs and beneficiaries from fraud, waste, and abuse, we strive to detect and prevent fraud and abuse, and to ensure that our programs provide high quality, necessary services, at appropriate payment levels.

Within the Department, the OIG is an independent organization, reporting to the Secretary and communicating directly with the Congress. We perform our mission through an organizational structure of regional and field offices staffed by auditors, investigators, evaluators, and analysts. We work closely with other law enforcement agencies, including the Department of Justice; the Inspectors Generals in other Federal agencies; State and local authorities; as well as private third-party payers.

One important indicator of the OIG's success over the years has been the savings accruing to the Federal Government as a result of our activities. Since 1981, the estimated return on Federal investment in OIG has totalled over $59 billion in fines, restitution, settlements, receivables, and savings to the Federal Government. Last year alone, the OIG generated fines, restitution, penalties, receivables, and savings of over $8 billion. These savings represent a substantial

increase over the years in the return to the public as a result of OIG activities: from $160,000 per OIG employee in FY 1981 to $6.4 million per OIG employee in FY 1994. Another perspective on this rate of increased savings over the years is to compare dollars appropriated to OIG to dollars saved as a result of OIG activity. In FY 1981, OIG generated savings of $4 for every dollar appropriated to it. This figure has grown to $80 for every dollar appropriated to OIG in FY 1994.

These savings come in three broad categories (See Chart 1, attached):

1. "Implemented Recommendations to Put Funds to Better Use" -- These amounts represent funds or resources that will be used more efficiently as a result of changes to legislation, regulations, policies and procedures implemented by the Congress or by HHS program managers in response to OIG recommendations. Implementation is considered to occur in the year legislation is passed, when final regulations are issued, or, in the case of administrative savings, when final action is taken by management.[1] The FY 1994 total was about $6.9 billion.

2. "Disallowances from OIG Questioned Costs" - These are amounts that have been identified for recovery as a result of management decisions in response to OIG audit and inspection findings and recommendations. For FY 1994, the total was $876 million.

[1] Legislative/regulatory savings are annualized figures drawn from 5-year budgetary savings projections as issued by Congressional Budget Office. Administrative savings are calculated by OIG using departmental figures for the year in which the change is effected, or if appropriate, for a projected multi-year period.

3. "Investigative Receivables" - This is the total of fines, savings, restitutions, settlements and recoveries accruing during the fiscal year from judicial or administrative processes that result from OIG investigations. They include both actual and court-ordered recoveries to the Treasury, the Social Security and Medicare trust funds, and Departmental programs victimized by fraud and abuse. For FY 1994, the total was $300 nillion.

With respect to the third category, investigative receivables, over the last five years every dollar devoted to OIG investigations of health care fraud and abuse has yielded an average return of nearly $7 to the Federal Treasury, Medicare trust funds, and State Medicaid programs, a return ratio of 7 to 1. In FY 1994 alone, the return ratio was $14 to one. (See Chart 2, attached) In addition, it is well established that law enforcement activity has a deterrent effect. Even though this deterrent effect cannot be readily quantified, it is an important additional "multiplier" of the dollars invested in health care fraud enforcement.

CURRENT HEALTH CARE DELIVERY SYSTEM - THE PROBLEMS

The Department's Health Care Financing Administration (HCFA) actuaries have estimated that national health care expenditures for 1994 were at least $938 billion. The Federal Government is the fastest growing payer of health care costs. Federal outlays are expected to exceed $177 billion for Medicare and $88 billion for Medicaid in FY 1995.

These national statistics must be considered in conjunction with a General Accounting Office (GAO) report issued several years ago which estimated that fraud and abuse in the health care

industry accounts for an estimated 10 percent of our yearly health care expenditures. In 1994, this would have approached $94 billion for all health care programs.

Because there is no indication that fraud and abuse in the health care industry is abating, we are seeking to broaden our investigative, audit, evaluation, and sanction activities. Certainly, I believe we have been successful in combating fraud, but I can also tell you that I think there is much to be done. While we have found that fraud and abuse permeate all aspects of the Medicare program and all areas of the country, we believe that some program areas are more vulnerable than others. Vulnerabilities in three specific program areas -- home health agencies, nursing facilities, and medical equipment and supplies -- have been of particular concern to us.

OPERATION RESTORE TRUST

As a result of these concerns, a new effort to combat health care fraud, waste, and abuse called Operation Restore Trust has been established to target these areas. We have focused attention on five States: California, Florida, New York, Texas, and Illinois. Together, these States account for 40 percent of the nation's Medicare and Medicaid beneficiaries. Operation Restore Trust is composed of an interdisciplinary team of Federal and State Government including our office, HCFA, the Administration on Aging, the Department of Justice, State Medicaid agencies, and State Medicaid Fraud Control Units.

Already, investigations, audits, and evaluations conducted by our office, and special program initiatives and analysis by HCFA, are showing that these three areas are particularly susceptible to fraud and abuse. As part of Operation Restore Trust we plan to issue a number of Special Fraud

Alerts which are designed to raise awareness regarding program abuses among beneficiaries and providers. We recently issued such an alert on home health fraud and I would like to submit a copy for the record. An alert on nursing homes will be issued in the near future.

Let me briefly discuss each of the Operation Restore Trust areas.

Home Health

In FY 1990 the Medicare program spent $3.3 billion on home health. Program expenditures in this area are expected to reach $14 billion this year and more than $21 billion by the year 2000, if left uncontrolled. Numerous factors have contributed to this recent growth in expenditures, including increases in both the number of beneficiaries using home health services and the average number of visits per beneficiary.

However, we are concerned that part of this increase may be the result of fraud. In the home health industry, fraud we have observed has included billing for excessive services or for services not rendered, the use of unlicensed or untrained staff, falsified plans of care, forged physician signatures, and kickbacks.

For example, we have an ongoing investigation of First American Health Care, Inc. (formally known as ABC Home Health Services, Inc.). In this case, we have been working with the U.S. Attorney to pursue both criminal and civil charges against the company. During the course of an investigation begun in 1990, we determined that ABC charged certain costs to the Medicare program that were unrelated to Medicare patient care. Later, when we formally audited the

agency's Medicare cost report, we found that ABC claimed approximately $14 million in unallowable costs during one cost reporting year. The unallowable costs included items such as utility and maid service payments for the owners' condominium and golf pro shop expenses; airplane and automobile expenses for personal trips; and lobbying expenses. Other unallowable costs included $1.2 million for a conference; almost $600,000 for marketing and promotional activities, including expenditures for gourmet popcorn, ABC golf tees, ABC earrings and cufflinks, and ABC combs and sewing kits; and over $200,000 for entertainment and gifts. As a result of our investigation and subsequent audit, the OIG has proposed to exclude this entity from the Medicare, Medicaid, and all State health programs for a period of 7 years. ABC has requested a hearing on the proposed exclusion and the case has been assigned to an Administrative Law Judge. A hearing may commence in late November or early December.

We also audited St. John's home health agency in Miami Lakes, Florida and found that 75 percent of the claims (or more than $25 million) submitted by this HHA did not meet Medicare guidelines. We conducted a review of home health claims in Florida and found that 26 percent of claims did not meet Medicare guidelines.

Most recently, we completed an analysis of Medicare payments to home health agencies. We analyzed payments made by Medicare to HHAs, and the number of visits they provided. The highest group of home health agencies received, on average, five times the amount of Medicare reimbursement per beneficiary as the lower group. The average number of visits per beneficiary, by HHA, varied from 141 in highest group to 27 visits in the lowest group. Higher group HHAs tended to be proprietary for profit, nonaffiliated organizations. Differences in quality of service

and beneficiary characteristics did not explain the variation in reimbursement or visits. We recommended that HCFA target the higher cost HHAs for further review, and continue to work on programmatic improvements to the home health benefit to prevent abuse.

Nursing Facilities

As a general matter, we are concerned about the provision of services and equipment to beneficiaries in nursing facilities because there are a multiplicity of providers who provide services to the beneficiaries. No single individual or institution is held responsible for managing the beneficiary's care and ensuring that only needed services are delivered to the patient. Indeed, many of the incentives run in quite the opposite direction.

We are also concerned that there is cost shifting between Part A and Part B of the Medicare program in the provision of Skilled Nursing Facility (SNF) services. For some services such as durable medical equipment, SNFs must bill Medicare Part A on the cost report and cannot bill Medicare Part B. However, we found that more than $10 million was incorrectly billed to Part B for durable medical equipment provided to Medicare beneficiaries in SNFs in 1992. For other services, program requirements are less clear and the SNF has the option of billing Medicare Part A on the cost report or having suppliers bill Medicare Part B directly. As a result, we found that about $57 million in total enteral nutrition charges were allowed in 1992 under Part B. In addition, as much as $55 million in 1992 were charged to Part B for rehabilitation therapy and as much as $44 million was paid under Part B for surgical dressings, incontinence supplies, braces, catheters, and similar items.

Savings could result if these items were purchased by the nursing facility, acting as a prudent purchaser and taking advantage of discounts, rather than being billed to Part B and reimbursed under fee schedules. We also note that when services are billed under Part B, the beneficiary is liable for coinsurance and deductibles. In 1992, beneficiaries whose stays in SNFs were covered by Medicare paid up to $99 million as their coinsurance and deductibles for therapy, nutrition, and medical supplies and equipment billed under Part B.

The HCFA shares our concerns about fragmentation of billing for services delivered to Medicare beneficiaries in nursing facilities and is working on possible solutions. One option would be a statutory "rebundling" provision for SNFs, similar to that for hospitals. Such an approach would also support work to establish a prospective payment system for beneficiaries in SNFs.

Medical Equipment and Supplies

The third program area targeted by Operation Restore Trust is durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). In fact, many of the abuses we observe in nursing facilities implicate suppliers. For many years, we have issued reports documenting fraudulent, abusive and wasteful practices in the medical equipment and supplies area. The attention devoted to this area has resulted in significant reforms being undertaken including changing point-of-sale rules and how billing numbers are issued. However, we know that certain abuses continue and that additional corrective action can be taken to reduce program vulnerabilities. While DMEPOS represents a relatively small part of the Medicare program, it serves as a good illustration of some of the abuses in the program and the ease or difficulty in which program modifications are made.

Durable medical equipment are items that can withstand repeated use and include oxygen equipment, hospital beds, wheelchairs, transcutaneous electrical nerve stimulators (TENS), seat-lift mechanisms, and other equipment that physicians prescribe for home use. Prosthetics and orthotics are devices that replace all or part of an internal body organ and include leg, arm, back, and neck braces as well as artificial legs, arms, and eyes. Medical supplies include catheter supplies, ostomy supplies, incontinence supplies, and wound care supplies. For certain pieces of equipment and supplies, suppliers submit claims along with authorization documents known as certificates of medical necessity (CMNs) prepared by a physician. Medicare expenditures for medical equipment and supplies now exceed $3 billion a year.

Over the years, we have worked with HCFA, the Congress and the medical equipment industry to document fraudulent and abusive practices, including questionable marketing techniques, inflated charges, and manipulation of loopholes in the law. Not only does the Federal Government lose millions of dollars a year on these schemes, but these practices are particularly offensive because they victimize our beneficiaries. We are pleased that our work in this area has contributed to heightened awareness of the deficiencies in payment and coverage policy for medical equipment and supplies.

We have aggressively pursued those who have defrauded our programs in this area. Between 1990 and 1994, our investigations led to 131 successful criminal prosecutions of DME suppliers or their employees. During the same period, we imposed 38 civil money penalties. In the last 2 years alone, we excluded 114 DME companies or their employees from the Medicare and Medicaid programs.

We often take a close, hard look at specific items of equipment or supplies when we see a significant increase in payments over a short period of time. In the absence of coverage or coding changes, or new medical information about proper use and application of technology, such increases have often been an indication of fraud or inappropriate billings.

PROTECTING OUR HEALTH CARE FINANCING PROGRAMS IN THE FUTURE

Let me also address the broader issue of how we can best protect the Medicare and Medicaid programs from fraud and abuse in the future. If you were to ask what is different today from several years ago in the health care fraud and abuse enforcement arena, I would make three observations:

- Rising Medicare and Medicaid expenditures create a more attractive target for unscrupulous individuals;

- Fraud schemes are demonstrating increased sophistication and complexity; and

- Inadequate resources are available to address the problem of health care fraud and abuse.

When Willie Sutton was asked why he robbed banks, he responded: "Because that's where the money is." Today's criminals continue to be attracted to the money. In 1980, Medicare program costs were $34 billion. In 1990, that number had increased to $107 billion; and estimated

Medicare costs in 1995 are $177 billion. With that much money at stake, the lure of a fast buck is irresistible to the hardened criminal as well as those who straddle the fence between honesty and dishonesty.

Second, we see a trend toward increased complexity and sophistication in the various schemes used to defraud the Medicare and Medicaid programs. When we first started investigating health care fraud almost 20 years ago, we were primarily seeing instances of individual providers filing false claims for relatively low dollar amounts. Today, we see increasingly complex fraud schemes involving groups of perpetrators, large national corporations, and huge dollar amounts. The health care fraud environment today involves complicated reimbursement issues, unique medical settings, and byzantine financial arrangements. Multi-million dollar companies are being built upon substandard medical services and supplies, illegal kickbacks, and false claims for reimbursement. Several major cases investigated and resolved by the Government during the past several years are illustrative of this phenomenon:

- A major national corporation (National Health Labs, Inc.) agreed to resolve outstanding fraud charges relating to the submission of false claims for laboratory test panels by paying in excess of $110 million to the Government.

- Another large corporation (National Medical Enterprises, Inc.), which owned and operated over 60 psychiatric hospitals, agreed to settle the Government's fraud claims relating to kickbacks and unnecessary services

by entering into a criminal plea agreement and agreeing to pay $379 million in penalties and restitution.

- Most recently, Caremark International, Inc., a national provider of intravenous medication and nutrition to patients in their homes, agreed to plead guilty to paying kickbacks to physicians to lure patients for treatment, and to pay approximately $161 million in civil damages and criminal fines.

The size and complexity of these cases highlight the need for increased resources dedicated to identifying and fighting health care fraud and abuse.

Third, despite increasing demands, the OIG's investigative and audit resources have declined during the past several years, from 1411 employees in 1991 to just over 900 today (after 259 positions were transferred to create the Office of Inspector General at the newly independent Social Security Administration). As a result, we have had to close 17 OIG investigative offices; and we now lack a presence in 24 States. Budget constraints have produced the illogical result that spending on fraud prevention and detection -- activities that pay for themselves many times over -- has actually been curtailed.

RESOURCES

The Secretary of Health and Human Services has been very supportive of the need to adequately fund activities to combat health care fraud and abuse. But there is only so much that can be done given current budget constraints on discretionary spending. Because of the difficulty in obtaining

adequate resources to address health care fraud and abuse, we support a mechanism to increase funding without increasing the deficit or further burdening taxpayers. Under this concept, certain recoveries generated by our health care anti-fraud activities would be deposited into a reinvestment fund with dollars available to fund additional enforcement activities. Thus, the individuals who actually perpetrate fraud against, or otherwise abuse our nation's health care system, would foot the bill for increased policing of those programs. Of course, restitution to the Medicare trust funds and the affected Medicaid programs would be made before any monies could be deposited into the account. And because these funds would yield substantial savings to the Medicare and Medicaid programs, the Federal deficit would be decreased rather than increased by this mechanism.

There are several bills currently under review in the Congress that would establish this process. We urge prompt enactment.

COMMUNICATION

Clearly, if we are to maximize resources for fighting health care fraud and abuse, we need to enhance communication between Federal and State, as well as private third party payers. Accordingly, we support the proposal to establish a Health Care Fraud and Abuse Data Collection Program. It is important that Federal, State, and local governments, as well as private third party payers, communicate with one another with respect to aberrant providers. The establishment of a central repository for the reporting of final adverse actions taken against health care providers will permit Federal, State, and private payers to become aware of and take reciprocal actions to sanction health care providers who abuse or defraud health care financing programs. We would suggest that this data bank also be made available to the public so that patients can be informed and

vigilant about health care providers and practitioners whom they utilize.

CONCLUSION

As the Congress considers ways to reduce the costs of health care, it is imperative to focus on the problems of fraud, waste and abuse. Billions of dollars could potentially be saved by a more aggressive approach. We look forward to working with the Committee to enhance resources, coordination, remedies, and communication focused on health care fraud and abuse in our country today.

This concludes my prepared testimony. I would be happy to answer any questions you may have.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
FY 1994 SAVINGS

(in millions)

Funds Put to Better Use		Audit Disallowances		Investigative Receivables	
Health Care	$4,373.3	Health Care	$754	Health Care	$264
SSA	2,509.9	OS	99	Savings	22
PHS	11.3	Other	23	Other	14
TOTAL	**$6,894.5**	**TOTAL**	**$876**	**TOTAL**	**$300**

Department of Health and Human Services
Office of Inspector General
Office of Investigations

Fiscal Year	Medicare and Medicaid Investigative Recoveries[1] (in millions)	OIG Health Care Investigative Costs[2] (in millions)	Return Ratio
1990	$23.8	$16.2	1.5 to 1
1991	52.3	15.0	3.5 to 1
1992	44.2	14.8	3 to 1
1993	171.2	16.0	11 to 1
1994	264.0	18.9	14 to 1
TOTALS	**$550.5**	**$80.9**	7 to 1

[1]Federal, Civil and Administrative health care fraud cases
[2]DOJ costs not included

P85 ZENO726A

OFFICE OF INSPECTOR GENERAL

SPECIAL FRAUD ALERT

Home Health Fraud

June 1995

The Office of Inspector General was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse and waste in Health and Human Services programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections.

To help reduce fraud and abuse in the Medicare and Medicaid programs, the OIG actively investigates schemes to fraudulently obtain money from these programs and, when appropriate, issues Special Fraud Alerts which identify segments of the health care industry that are particularly vulnerable to abuse. This Special Fraud Alert focuses on the home health industry and identifies some of the illegal practices the OIG has uncovered.

What is Home Health Care and Who is Eligible to Receive It?

Medicare's home health benefit allows people with restricted mobility to remain non-institutionalized and receive needed care at home. Home health services and supplies are typically provided by nurses and aides under a physician-certified plan of care.

Medicare will pay for home health services if a beneficiary's physician certifies that he or she:

- is homebound -- i.e., confined to the home except for infrequent or short absences or trips for medical care, and
- requires one or more of the following qualifying services: physical therapy, speech-language pathology, or intermittent skilled nursing.

If a homebound patient requires a qualifying service, Medicare also covers services of medical social workers and certain personal care such as bathing, feeding, and assistance with medications. However, a beneficiary who needs only this type of personal or custodial care does not qualify for the home health benefit.

(OIG 95-08)

Fraud and Abuse in the Home Health Industry

Home care is consuming a rapidly increasing portion of the federal health budget. This year, Medicare payments for home health will reach close to $16 billion, up from $3.3 billion in 1990 -- nearly a five fold increase. Home health care is particularly vulnerable to fraud and abuse because:

- Medicare covers an unlimited number of visits per patient;
- Beneficiaries pay no co-payments except on medical equipment;
- Patients don't receive explanations of benefits (EOBs) for bills submitted for home health services; and
- There is limited direct medical supervision of home health services provided by non-medical personnel.

The OIG has learned of several types of fraudulent conduct, outlined below, which have or could result in improper Medicare reimbursement for home health services.

False or Fraudulent Claims Relating to the Provision of Home Health Services

The government may prosecute persons who submit or cause false or fraudulent claims for payment to be submitted to the Medicare or Medicaid programs. Examples of false or fraudulent claims include claims for services that were never provided, duplicate claims submitted for the same service, and claims for services to ineligible patients. A claim for a service that a health care provider knows was not medically necessary may also be a fraudulent claim.

Submitting or causing false claims to be submitted to Medicare or Medicaid may subject a person to criminal prosecution, civil penalties including treble damages, and exclusion from participation in the Medicare and Medicaid programs. OIG has uncovered the following types of fraudulent claims related to the provision of home health services.

Claims For Home Health Visits That Were Never Made And For Visits to Ineligible Beneficiaries

OIG has uncovered instances where home health agencies are submitting false claims for home health visits. These include:

- **Claims for visits not made.**
- **Claims for visits to beneficiaries not homebound.**
- **Claims for visits to beneficiaries not requiring a qualifying service.**
- **Claims for visits not authorized by a physician.**

One home health agency billed Medicare for 123 home health visits to a patient who never received a single visit, and submitted claims for beneficiaries who were in an acute care hospital during the period the agency claimed to have provided home visits. Another agency provided a home health aide to a beneficiary so mobile that he volunteered at a local hospital several times a week.

A third agency claimed nearly $26 million during one year in visits that were not made, visits to patients that were not homebound, and visits not authorized by a physician. OIG interviews indicated that beneficiary signatures were forged on visit logs and physician signatures were forged on plans of care. This agency had subcontracted with other entities to provide home health care to its patients, and claimed that the subcontractors falsely documented that visits were made and services were provided.

Medicare permits a home health agency to contract with other organizations, including agencies not certified by Medicare, to provide care to its patients. However, the agency remains liable for all billed services provided by its subcontractors. The use of subcontracted care imposes a duty on home health agencies to monitor the care provided by the subcontractor.

Home health agencies, as well as the physicians who order home health services, are responsible for ensuring the medical necessity of claims submitted to Medicare. A physician who orders unnecessary home health care services may be liable for causing false claims to be submitted by the home health agency, even though the physician does not submit the claim. Furthermore, if agency personnel believe that services ordered by a physician are excessive or otherwise inappropriate, the agency cannot avoid liability for filing improper claims simply because a physician has ordered the services.

Fraud in Annual Cost Report Claims

In addition to submitting claims for specific services, home health agencies submit annual cost reports to Medicare for reimbursement of administrative, overhead and other general costs. For these costs to be allowable, Medicare regulations require that they be (1) reasonable, (2) necessary for the maintenance of the health care entity, and (3) related to patient care. However, the OIG has audited cost reports which include costs for entertainment, travel, lobbying, gifts, and other expenses unrelated to patient care such as luxury automobiles and cruises. One home health agency claimed several million dollars in unallowable costs during one cost reporting year. These included utility and maid service payments for the owner's condominium, golf pro shop expenses, lease payments on a luxury car for the owner's son at college, and payment of cable television fees for the owner's mother.

Medicare also requires home health agencies to disclose in their cost reports the identity of related parties with whom they conduct business, in order to adjust costs that are likely to be inflated by health care providers who self-deal (i.e., purchase goods or services from related companies). A related party issue exists when there is common control or common interest between the provider and the organization with whom it is doing business. OIG has investigated home health agencies which failed to disclose ownership or other relationships with entities with whom they contracted for accounting services, management/consulting services, and medical supplies. These agencies billed Medicare unallowable amounts for marked-up supplies and services.

Paying Or Receiving Kickbacks In Exchange For Medicare or Medicaid Referrals

Kickbacks in exchange for the referral of reimbursable home health services is another type of fraud that OIG has observed. The Medicare program guarantees freedom of choice to its beneficiaries in the selection of health care providers. Because kickbacks violate that principle and also increase the cost of care, they are prohibited under the Medicare and Medicaid programs. Under the anti-kickback statute, it is illegal to knowingly and willfully solicit, receive, offer or pay anything of value to induce, or in return for, referring, recommending or arranging for the furnishing of any item or service payable by Medicare or Medicaid.

OIG is aware of home health providers offering kickbacks to physicians, beneficiaries, hospitals, and rest homes in return for referrals. Kickbacks have taken the following forms:

- **Payment of a fee to a physician for each plan of care certified by the physician on behalf of the home health agency.**
- **Disguising referral fees as salaries by paying referring physicians for services not rendered, or in excess of fair market value for services rendered.**
- **Offering free services to beneficiaries, including transportation and meals, if they agree to switch home health providers.**
- **Providing hospitals with discharge planners, home care coordinators, or home care liaisons in order to induce referrals.**

- **Providing free services, such as 24 hour nursing coverage, to retirement homes or adult congregate living facilities in return for home health referrals.**
- **Subcontracting with retirement homes or adult congregate living facilities for the provision of home health services, to induce the facility to make referrals to the agency.**

Parties that violate the anti-kickback statute may be criminally prosecuted, and also may be subject to exclusion from the Medicare and Medicaid programs.

Marketing Uncovered Or Unneeded Home Care Services to Beneficiaries

OIG has learned of high pressure sales tactics employed by some agencies in the home health community to maximize their patient population and their profits. These agencies target healthy beneficiaries on the street or in their homes and offer non-covered services, such as grocery shopping or housekeeping, in exchange for Medicare identification numbers. Physicians have also reported that some agencies attempt to pressure them to order unnecessary personal care services by informing them that their patients are requesting these services and will find another physician if their demands are not met.

These abusive marketing practices can result in false claims liability on the part of agencies and/or physicians, and may also constitute illegal kickbacks.

What To do If You Have Information About Suspect Fraud Involving Delivery or Claims for Home Health Services

If you have information about home health agencies, physicians, or other individuals or entities engaging in any of the activities described above, contact any of the regional offices of the Office of Investigations of the Office of Inspector General, U.S. Department of Health and Human Services, at the following locations:

Regions	States Served	Telephone
Boston	MA, VT, NH, ME RI, CT	617-565-2660
New York	NY, NJ, PR, VI	212-264-1691
Philadelphia	PA, MD, DE, WV VA	215-596-6796
Atlanta	GA, KY, NC, SC FL, TN, AL, MS (No. District)	404-331-2131
Chicago	IL, MN, WI, MI IN, OH, IA, MO	312-353-2740
Dallas	TX, NM, OK, AR LA, MS (So. District)	214-767-8406
Denver	CO, UT, WY, MT, ND, SD, NE, KS	303-844-5621
Los Angeles	AZ, NV (Clark Co.) So. CA	714-836-2372
San Francisco	No. CA, NV, AZ, HI, OR, ID, WA	415-556-8880
Washington, D.C.	DC and Metropolitan areas of VA & MD	202-619-1900

To Report Suspected Fraud, Call or Write:

1-800-HHS-TIPS
Department of Health & Human Services
Office of Inspector General
P.O. Box 23489
L'Enfant Plaza Station
Washington, D.C. 20026-3489

(1) -- QUESTION FOR MS. BROWN

On page 15 of your prepared statement Ms. Brown, you refer to a mechanism to increase funding for Medicare and Medicaid anti-fraud efforts without increasing the deficit or further burdening taxpayers.

You state that under this concept, certain recoveries generated by health care anti-fraud activities would be deposited into a reinvestment fund with dollars available to fund additional enforcement activities. And you further state that restitution to the Medicare trust funds and to Medicaid would be made before any monies could be deposited into this new account.

In fact, the CBO testimony on page 10 also refers to such a mechanism which, in this case, is included in the proposed Administration bill and would be called the "HHS Fraud and Abuse Control Fund". I understand there is a similar provision contained in Senator Cohen's recently revised bill.

Let me just say that I have concerns that such a bounty hunter system would create an incentive for Federal investigators to pursue large civil penalties where they might otherwise not be appropriate in order to add to the trust fund.

In general, I find this concept troubling because, in fact, it may lead to unscrupulous anti-fraud activities by an over-zealous bureaucracy which is out to enhance its own mission.

I would appreciate your thoughts regarding my concerns and I would also welcome Mr. Owens' perspective.

To the best of my knowledge I'm not aware of any similar Federal mechanism, and I believe it may set the wrong precedent.

ANSWER: Considerable resources are needed to detect and pursue what has proven to be a tremendous volume of fraud and abuse within the health care industry.

As a practical matter, adequate resources to detect and pursue the large volume of health care fraud cases are currently unavailable, and unlikely to become available through the annual budget process.

The "Control Account" provision, contained in both the Administration's proposed bill and Senator's Cohen's recently revised bill, is a good way to get necessary resources for law enforcement. These are resources that are appropriately derived from those who have committed health care fraud or abuse.

The establishment of a Control Account will not create a "bounty system" nor encourage baseless charges for the following reasons:

- The justice system has too many checks and balances to allow the Fraud Account to operate as a "bounty" system. For example, if an investigative agency were to bring trumped-up cases, there are prosecutors, grand juries, petit judges and appellate judges that act as checks against meritless cases.

- The HHS IG, DOJ, and FBI are highly professional organizations that are experienced in investigating and pursuing cases of health care fraud and abuse. There is no reason to assume that the HHS IG, DOJ, and FBI will not continue to investigate and pursue fraud and abuse cases with the same integrity they have shown over the years.

- Of the more than 8,900 program sanctions (including exclusions and civil monetary penalties) imposed by the OIG during the past 11 years, only approximately 25 have been reversed.

- The Fraud Account will be controlled jointly by DOJ and the Secretary of HHS. Monies will be distributed to scores of entities responsible for combatting fraud and abuse. Amounts deposited into the Account will not directly revert to any one agency, thus limiting any "bounty system" incentive.

- Federal prosecutors do not have time for technical or trumped-up cases. There is more than enough real fraud to absorb all the effort of law enforcement agencies.

- Congress has continued oversight of the actions of the HHS IG and DOJ. These law enforcement entities would have to answer to Congress if there was evidence regarding abuse of the anti-fraud and abuse provisions.

STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN
SENATE SPECIAL COMMITTEE ON AGING
BEFORE THE SENATE COMMITTEE ON FINANCE
HEALTH CARE FRAUD AND ABUSE IN THE MEDICARE PROGRAM
JULY 31, 1995

GOOD MORNING MR. CHAIRMAN AND MEMBERS OF THE FINANCE COMMITTEE. I AM PLEASED TO ADDRESS THE COMMITTEE THIS MORNING ON HOW FRAUD AND ABUSE ARE DRIVING UP THE COST OF HEALTH CARE FOR TAXPAYERS AND ALL AMERICANS.

AS CHAIRMAN OF THE SENATE SPECIAL COMMITTEE ON AGING, I HAVE DIRECTED MY STAFF TO INVESTIGATE THE EXPLOSION OF FRAUD AND ABUSE THROUGHOUT THE HEALTH CARE SYSTEM, AND PARTICULARLY IN THE MEDICARE AND MEDICAID PROGRAMS. TARGETING FRAUD AND ABUSE OF MEDICARE AND MEDICAID, A HIGH PRIORITY OF THE AGING COMMITTEE, WAS PROMPTED BY ESTIMATES THAT AS MUCH AS TEN PER CENT OF HEALTH CARE SPENDING IN OUR NATION, AND OUR ECONOMY, IS LOST TO FRAUD AND ABUSE EACH YEAR. WHILE THE PRECISE NUMBERS ARE DIFFICULT TO VERIFY, IT IS CLEAR THAT OUR EFFORTS TO COUNTERACT THIS PROBLEM ARE MINIMAL AT BEST, AND THAT MEDICARE AND MEDICAID ARE SIMPLY LEAVING THEIR DOORS WIDE OPEN TO FRAUD AND ABUSE.

EVEN WORSE, ONCE THE THIEVES HAVE ENTERED THE SYSTEM, WE DO VERY LITTLE TO PUNISH THEM OR DISCOURAGE THEM FROM RIPPING OFF THE SYSTEM AGAIN. OUR PREVENTION AGAINST FRAUD AND ABUSE IS POOR, AND OUR ENFORCEMENT EFFORTS AGAINST HEALTH CARE VIOLATORS ARE WEAK. THIS FORMULA COMBINES TO LEAVE BILLIONS OF TAXPAYER AND MEDICARE TRUST FUND DOLLARS AT RISK TO FRAUD AND ABUSE.

A MAJOR VICTIM OF HEALTH CARE FRAUD IS THE AMERICAN TAXPAYER. AS MUCH AS $27 BILLION TAXPAYER DOLLARS ARE LOST TO FRAUD AND ABUSE IN MEDICARE AND MEDICAID, MONEY THAT COULD AND SHOULD BE GOING TOWARD PATIENT CARE. THE AGING COMMITTEE'S INVESTIGATION REVEALED THAT IT IS SHOCKINGLY SIMPLE TO COMMIT HEALTH CARE FRAUD, AND THAT THE SIZE, INTRICACY AND SPLINTERING OF THE CURRENT HEALTH CARE SYSTEM CREATE AN ENVIRONMENT RIPE FOR ABUSE. PAYERS ARE RUNNING AS FAST AS THEY CAN TO KEEP PACE WITH OVER FOUR BILLION CLAIMS FILED EACH YEAR, AND LAW ENFORCEMENT LACKS THE TOOLS AND RESOURCES NECESSARY TO MAKE A SIGNIFICANT DENT IN THE SCAMS.

AT A RECENT HEARING THAT I CONVENED, WE HEARD DISTURBING TESTIMONY FROM FBI DIRECTOR FREEH THAT ORGANIZED GROUPS ARE ACTIVELY ENGAGING IN HEALTH CARE FRAUD ON A LARGE SCALE.

PERPETRATORS RANGE FROM INTERNATIONAL ORGANIZED CRIME RINGS, AND FAKE UNIONS TO NETWORKS OF DOCTORS, SPECIALISTS, ATTORNEYS, AND PROFESSIONAL PATIENTS WHO GIN UP PHONY MEDICAL DIAGNOSES AND CONDITIONS, AND THEN BILL FOR TENS OF MILLIONS OF DOLLARS IN UNNECESSARY TESTS AND SERVICES. OUR INVESTIGATION HAS REVEALED THAT VIRTUALLY EVERY SECTOR OF THE HEALTH CARE INDUSTRY IS PLAGUED BY FRAUD AND ABUSE.

WHILE MOST HEALTH CARE PROVIDERS ARE HONEST PROFESSIONALS WITH THE BEST INTEREST OF THEIR PATIENTS IN MIND, FAR TOO MANY PROVIDERS HAVE LEARNED HOW TO MANIPULATE THE HEALTH CARE SYSTEM TO SERVE THEIR OWN FINANCIAL INTERESTS THROUGH FRAUD AND ABUSE.

CERTAIN AREAS OF THE HEALTH CARE SYSTEM ARE PARTICULARLY RIFE WITH FRAUD AND ABUSE. OVER THE PAST FOUR YEARS ALONE, MULTI-MILLION DOLLAR FRAUD SETTLEMENTS HAVE BEEN NEGOTIATED WITH MAJOR CLINICAL LABS, HOSPITALS, AND HOME CARE COMPANIES, WHILE MANY OTHER MAJOR NATIONAL HEALTH CARE PROVIDERS CONTINUE TO BE UNDER INVESTIGATION FOR ALLEGED HEALTH CARE FRAUD. THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TESTIFIED THAT THERE WERE PARTICULAR PROBLEMS IN THE HOME HEALTH INDUSTRY, IN SERVICES AND SUPPLIES THAT ARE DELIVERED IN NURSING HOMES, AND IN THE MEDICAL SUPPLIER INDUSTRIES.

THE ABUSES ARE SHOCKING TO AMERICAN TAXPAYERS. ONE HOME HEALTH COMPANY, FOR EXAMPLE, HAS BEEN CHARGED WITH BILLING THE MEDICARE PROGRAM FOR, AMONG OTHER THINGS, $85,000 IN GOURMET POPCORN GIVEN TO PHYSICIANS AS PROMOTIONAL ITEMS. OTHER ABUSES INVOLVE PADDING CLAIMS AND COST REPORTS TO MEDICARE, CHARGING THE GOVERNMENT AND BENEFICIARIES OUTRAGEOUS PRICES FOR "UNBUNDLED" SERVICES, AND BILLING MEDICARE FOR COSTS THAT HAVE NOTHING TO DO WITH PATIENT CARE.

WHILE MEDICARE AND MEDICAID ACCOUNT FOR THE LARGEST PORTIONS OF FEDERAL HEALTH CARE SPENDING, THEY DON'T HAVE A CORNER ON THE HEALTH CARE FRAUD MARKET. OUR INVESTIGATION FOUND THAT FRAUD IS RAMPANT IN OTHER FEDERAL HEALTH CARE PROGRAMS, SUCH AS CHAMPUS, THE FEDERAL EMPLOYEES' WORKERS COMPENSATION PROGRAM, AND THE BLACK LUNG PROGRAM.

LAST CONGRESS, I INTRODUCED LEGISLATION TO TOUGHEN OUR DEFENSES AGAINST FRAUD AND ABUSE. AS MANY OF YOU REMEMBER, MY LEGISLATION WAS INCORPORATED INTO MANY OF THE HEALTH CARE REFORM

PROPOSALS CONSIDERED LAST YEAR. MANY MEMBERS OF THIS COMMITTEE, BOTH REPUBLICAN AND DEMOCRAT, WERE CO-SPONSORS. UNFORTUNATELY, HOPES FOR ENACTMENT OF ANTI-FRAUD AND ABUSE LEGISLATION FADED AS HEALTH CARE REFORM WAS DEFERRED.

EARLIER THIS YEAR I INTRODUCED S. 245, THE HEALTH CARE FRAUD PREVENTION ACT, A BILL DESIGNED TO PROVIDE ENHANCED PENALTIES AND RESOURCES TO ANTI-FRAUD ACTIVITIES. I AM PLEASED THAT SENATORS DOLE, SIMPSON, NICKLES, AND OTHER MEMBERS OF THIS COMMITTEE ARE COSPONSORS. THIS IS AN ISSUE THAT IS TRULY NON-PARTISAN, SINCE EACH OF US, REGARDLESS OF PARTY, WANT TO DO ALL WE CAN TO RID THE HEALTH CARE SYSTEM OF FRAUD AND ABUSE.

JUST TWO MONTHS AGO, THE SENATE VOTED 99-0 IN FAVOR OF A BUDGET RESOLUTION AMENDMENT I SPONSORED THAT STATED THAT HIGH PRIORITY SHOULD BE GIVEN TO PROPOSALS WHICH IDENTIFY, ELIMINATE, AND RECOVER FUNDS EXPENDED FROM THE MEDICARE PROGRAM DUE TO FRAUD AND ABUSE IN THE PROGRAM.

SINCE INTRODUCING S. 245 IN JANUARY, I HAVE SOUGHT EXTENSIVE INPUT ON THIS PROPOSAL FROM LAW ENFORCEMENT AGENCIES, HEALTH CARE EXPERTS, AND HEALTH CARE PROVIDERS THEMSELVES IN ORDER TO ENSURE THAT HEALTH CARE FRAUD LEGISLATION STRIKE THE APPROPRIATE BALANCE BETWEEN STRONG ENFORCEMENT AGAINST INTENTIONAL VIOLATIONS OF HEALTH CARE FRAUD AND ABUSE, AND FAIR TREATMENT OF HEALTH CARE PROVIDERS.

IT IS CRITICAL THAT ANY LEGISLATION ENACTED IN THIS AREA BE WORKABLE AND BALANCED, AND NOT UNDULY BURDEN HEALTH CARE PROVIDERS AND BUSINESSES. ENFORCEMENT MUST BE TOUGH AND CERTAIN, BUT HONEST HEALTH CARE PROVIDERS MUST NOT BE TRAPPED OR OVERBURDENED BY COMPLICATED OR VAGUE HEALTH CARE FRAUD RULES. OVER THE PAST SEVERAL MONTHS I HAVE WORKED WITH LAW ENFORCEMENT AND PROVIDER REPRESENTATIVES TO REFINE THE PROVISIONS OF MY HEALTH CARE FRAUD PROPOSALS TO STRIKE THE APPROPRIATE BALANCE.

AS A RESULT, LAST WEEK I INTRODUCED A REVISED VERSION OF MY LEGISLATION. THE PROPOSAL WOULD ESTABLISH AN ANTI-FRAUD AND ABUSE PROGRAM TO HELP COORDINATE ENFORCEMENT ACTIVITIES TO PREVENT, DETECT, AND PROSECUTE HEALTH CARE FRAUD; TOUGHEN FEDERAL CRIMINAL LAWS AND ENFORCEMENT TOOLS AVAILABLE TO PURSUE HEALTH CARE FRAUD, AND INCREASE RESOURCES TO THOSE CHARGED WITH COMBATING FRAUD AND

ABUSE; AND PROVIDE A GREATER RANGE OF ENFORCEMENT REMEDIES TO RESPOND TO FRAUDULENT AND ABUSIVE SCHEMES.

MR. CHAIRMAN, I AM PLEASED TO NOTE THAT MANY PROVIDER GROUPS ARE TAKING THE INITIATIVE TO CRACK DOWN ON THOSE IN THEIR PROFESSIONS WHO ARE GIVING THEIR INDUSTRIES A BLACK EYE. UNFORTUNATELY, VOLUNTARY EFFORTS BY INDUSTRY ARE NOT ENOUGH. WE NEED A COORDINATED, ADEQUATELY STAFFED ANTI-FRAUD ENFORCEMENT EFFORT IN ORDER TO BE SUCCESSFUL IN COUNTERING HEALTH CARE FRAUD AND ABUSE.

WHILE I RECOGNIZE THAT WE WILL NOT BE ABLE TO RECOVER ALL THE DOLLARS LOST TO FRAUD, WE MUST ACT RIGHT NOW TO COMBAT THIS GROWING PROBLEM. IF WE ARE ASKING HONEST HEALTH CARE PROVIDERS TO TAKE CUTS IN REIMBURSEMENT LEVELS AND MEDICARE AND MEDICAID RECIPIENTS TO PAY MORE OUT-OF-POCKET TO BRING MEDICARE SPENDING UNDER CONTROL, IT IS OUR OBLIGATION TO DO ALL WE CAN TO ENSURE THE AMERICAN PUBLIC THAT HEALTH CARE DOLLARS ARE NOT BEING WASTED ON FRAUD AND ABUSE. WE CAN NO LONGER AFFORD TO SIMPLY ISSUE UNSCRUPULOUS PROVIDERS A CREDIT CARD, WITH AN OPEN-ENDED CREDIT LIMIT, AND FREE LICENSE TO CHARGE THE GOVERNMENT.

I STRONGLY URGE THE COMMITTEE TO MOVE QUICKLY ON MY LEGISLATION THAT IS NOW PENDING IN THIS COMMITTEE. WE SIMPLY CANNOT AFFORD TO PASS UP ANOTHER OPPORTUNITY TO MAKE SERIOUS HEADWAY IN THE FIGHT AGAINST HEALTH CARE FRAUD.

STATEMENT BY
SENATOR ORRIN G. HATCH
COMMITTEE ON FINANCE
HEARING ON MEDICARE FRAUD AND ABUSE
JULY 31, 1995

First of all, I want to express my appreciation to the Chairman and his staff for the outstanding work you have done in arranging these hearings on Medicare reform.

As has been said here many times, the issues of Medicare reform are complex and difficult. The decisions we make in the course of the next several months will not only affect the lives of the 37 million Americans currently on Medicare, but the lives of future beneficiaries as well.

I believe these hearings have laid a solid framework from which we can move forward toward meaningful reform to ensure Medicare's survival well into the next century.

So once again, I commend the Senator and his excellent staff for your hard work. Although, without doubt the hardest part of this process is yet to come for all of us.

Today's hearing focuses on one of the most troubling aspects of health care in our country. The deliberate and unscrupulous act of defrauding individuals, health care providers, and state and federal governments in the provision of health care.

By most estimates, the costs of health care in the United States approach $1 trillion annually. By the turn of the century, the figure will exceed $1.5 trillion, consuming up to 16% of the nation's gross domestic product.

According to the Congressional Budget Office, Medicare spending will more than double from the current sum of $181 billion to $463 billion in the year 2005. Billions of dollars, even by the most conservative estimates, are being lost to waste, fraud, and abuse. These losses are clearly not insignificant.

Since health insurance experts, the FBI, and other agencies agree that fraud and abuse can account for as much as 5% to 10% of these costs, then any effort to rein in health spending needs to address this problem.

I would also like to thank the witnesses for their testimony today and the expertise that they bring to this hearing.

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MEDICARE

Modern Management Strategies Could Curb Fraud, Waste, and Abuse

Statement of Sarah F. Jaggar, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-95-227

Mr. Chairman and Members of the Committee:

We are pleased to be here today as this Committee explores the problems of waste, fraud, and abuse in the Medicare program. As we have documented in numerous reports and other congressional testimony, billions of dollars could be saved by curbing questionable, abusive, and exploitative billing. (See app. I for a list of related GAO products.)

Drawing upon the extensive work we have done on Medicare, I would like to focus my remarks today on the factors that make the program an appealing target for fraud and abuse and on the health care management strategies used by the private sector to deal with similar problems.

In brief, our work has shown that Medicare's vulnerability stems from a combination of factors: (1) higher-than-market rates for certain services, (2) inadequate checks for detecting fraud and abuse, (3) superficial criteria for confirming the authenticity of providers billing the program, and (4) weak enforcement efforts. Various health care management techniques help private payers alleviate these problems, but these techniques are not generally used in Medicare. The program's pricing methods and controls over utilization, consistent with health care financing and delivery 30 years ago, are not well aligned with today's major financing and delivery changes. To some extent, the predicament inherent in public programs--the uncertain line between adequate managerial control and excessive government intervention--helps explain the dissimilarity in the ways Medicare and private health insurers administer their respective "plans."

We believe a viable strategy for remedying the program's weaknesses consists of adapting the health care management approach of private payers to Medicare's public payer role. Such a strategy would focus on pre-enforcement and would entail (1) more competitively developed payment rates, (2) enhanced fraud and abuse detection efforts through modernized information systems, and (3) more rigorous criteria for granting authorization to bill the program.

BACKGROUND

Medicare is the nation's largest single payer of health care costs. In 1994, it spent $162 billion, or 14 percent of the federal budget, on behalf of about 37 million elderly and disabled people. Approximately 90 percent of Medicare beneficiaries obtained services on an unrestricted fee-for-service basis; that is, patients chose their own physicians or other health care providers, with charges sent to the program for payment. This setup mirrored the nation's private health insurance indemnity plans, which prevailed until the 1980s.

Since then, revolutionary changes have taken place in the financing and delivery of health care. Greater competition among hospitals and other providers has enabled health care buyers to be more selective. Private payers, including large employers, use an aggressive management approach to control health care costs. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), is Medicare's health care buyer. HCFA's pricing of services and controls over utilization have been carefully prescribed by interrelated statute, regulation, and agency policy.

HCFA contracts with about 72 private companies--such as Blue Cross and Aetna--to handle claims screening and processing and to audit providers. Each of these commercial contractors works with its local medical community to set coverage policies and payment controls. As a result, billing problems involving waste, fraud, and abuse are handled, for the most part, at the contractor level. This arrangement was prompted when the program was established in the mid-1960s by concerns that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

ABOVE-MARKET RATES FOR MANY SERVICES ENCOURAGE OVERSUPPLY

Medicare pays substantially higher than market rates for many services. For example:

-- The HHS Office of Inspector General reported in 1992 that Medicare paid $144 to $211 each for home blood glucose monitors when drug stores across the country sold them for under $50 (or offered them free as a marketing ploy).[1] HCFA took nearly 3 years to reduce the price to $59.

-- For one type of gauze pad, the lowest suggested retail price is currently 36 cents. The Department of Veterans Affairs (VA) pays only 4 cents. Medicare, however, pays 86 cents for this pad. Indeed, Medicare pays more than the lowest suggested retail price for more than 40 other surgical

[1]Home blood glucose monitors enable individuals to determine the adequacy of their blood glucose levels. The manufacturers have an incentive to promote the sale of their brand of monitor to ensure future sale of related test strips. According to HCFA, the income generated in 1 month by the sale of test strips can exceed the total income generated from the sale of the monitors.

dressings. Medicare pays more than VA for each of the nine types of dressing purchased by both VA and Medicare. For all practical purposes, HCFA is prohibited from adjusting the prices for these and similar supplies.[2]

-- Medicare was billed $8,415 for therapy to one nursing home resident, of which over one-half--$4,580--was for charges added by the billing service for submitting the claim. Such practices escape notice because, for institutional providers, Medicare allows almost any patient-related costs that can be documented.

HCFA officials told us that resources are not available to routinely check market prices for items covered by Medicare. Yet such excessive payment rates can encourage an oversupply of services and thus foster a climate ripe for abuse. Further, our work has shown that HCFA's inability to systematically review payment rates as technologies mature and become more widely used and as providers' costs per service decline can support the proliferation of costly technology. Magnetic resonance imaging (MRI) equipment is a case in point, as we reported in 1992.[3] In the absence of systematic adjustment, the Congress has had to act several times, specifically reducing rates for various procedures and services, such as overpriced surgeries, selected durable medical equipment items, intraocular lenses, CT scans, and MRIs.

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[2]42 U.S.C. 1395m(i) required HCFA to establish a fee schedule for surgical dressings based on average historical charges. However, in March 1994, Medicare's surgical dressing benefit was greatly expanded to include various types and sizes of gauze pads not previously covered and to extend the duration of coverage to whatever is considered medically necessary. Because the benefit was expanded, HCFA did not have historical charge data. Instead, it used a gap-filling process based on the median price in supply catalogs. The median is necessarily higher than the lowest price (given any variation at all). HCFA cannot change the methodology for determining the fee schedule nor can it adjust the schedule if retail prices decrease. While HCFA is authorized to increase payments annually based on the consumer price index, it lacks authority to reduce such payments.

[3]Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

EVIDENCE OF ABUSIVE BILLING INDICATES MEDICARE'S CHECKS ON PAYMENTS ARE NOT ADEQUATE

Medicare's claims processing contractors employ a number of automated controls to prevent or remedy inappropriate payments.[4] Although these measures are effective in some instances, abusive claims costing billions of dollars escape detection. For example, contractors which process claims for medical equipment and supplies do not necessarily review high-dollar claims for newly covered surgical dressings. In consequence, one such contractor paid $23,000 when the appropriate payment was $1,650. Similarly, Medicare paid a psychiatrist over a prolonged period for claims that represented, on average, nearly 24 hours a day of services. Automated controls failed to identify either of these abuses.

In congressional testimony earlier this year, we reported the results of our study on private sector computer software controls used to detect certain billing abuses.[5] We compared what Medicare actually paid providers against what would have been allowed by four commercial firms that market computerized systems to detect miscoded claims.[6] We invited each firm to reprocess 200,000 statistically selected claims that Medicare paid in 1993. On the basis of this sample, we estimated that, had Medicare used this commercial software, the government would have saved $3 billion over 5 years by detecting these billing abuses.

Enhancement of payment controls is problematic in the current fiscal environment. Contractor resources are a major factor here. On a per claim basis, funding for contractors has declined in recent years, as shown in table 1. As a consequence,

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[4]Some controls are designed to stop processing when claims do not meet certain conditions for payment. For example, one control flags claims that exceed the allowed threshold of 12 chiropractic manipulations a year per beneficiary. Other controls automatically deny claims or recalculate payment amounts. A third kind of control, postpayment review of data, is intended to enable Medicare to spot patterns and trends of unusually high spending.

[5]See Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133) and Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135), both issued May 5, 1995.

[6]Providers bill their charges to Medicare according to an official book of procedure codes. By manipulating these codes, a provider can charge Medicare more than the appropriate code would permit.

we have found instances where automated controls that flag claims for further review have been turned off for lack of staff to follow up.

Table 1: Per Claim Funding of Medicare Contractors for Selected Activities

Activity	1989 budget (actual)	1995 budget (estimated)	Percent decrease	
			Not adjusted for inflation	Adjusted for inflation
Medical review of claim	$0.32	$0.15	54.4	61.8
All payment safeguards	$0.74	$0.50	32.7	43.6
Total contractor budget	$2.74	$2.05	25.1	37.2

Although heavier reliance on automated controls that do not require manual review would help, automation alone will not solve the problem of decreasing resources, because many decisions require the judgment of trained medical personnel. Noting that every dollar spent on Medicare safeguard activities returns at least $11, we and others have proposed that additional funds be provided to at least keep pace with the growth in claims processed. In large part, the decline in program spending for these activities corresponds with passage of the Budget Enforcement Act of 1990. That act established limits--or caps--on domestic discretionary spending, including spending for Medicare safeguard activities. Exceeding these caps in one domestic discretionary account requires budget reductions in other accounts, such as those for education or welfare. This means that even though appropriating additional funds for safeguard activities would result in a net budgetary gain, under current law it would necessitate offsetting cuts in other areas. Recognizing a similar situation with respect to Internal Revenue Service compliance activities, the 1990 act included a limited exception to the spending caps to facilitate adequate funding for such compliance activities. Therefore, the Congress is able to increase funds for such activities without cutting funding for other domestic discretionary programs. If a similar exception was provided for Medicare program safeguards activities, it could ultimately lead to significant savings to the federal government.

INSTANCES OF BILLING SCAMS SUGGEST MEDICARE'S CHECKS OF PROVIDER BUSINESSES ARE SUPERFICIAL

Our studies and those of the HHS Inspector General have found that unscrupulous individuals or companies can be authorized to bill Medicare even if they do not qualify as legitimate providers. This puts them in a position---from within Medicare--to deploy fraudulent or abusive billing schemes. This problem has become more acute as providers that are less scrutinized or more transient than doctors and hospitals use elaborate, multilayered corporations to bill Medicare.

The following examples show instances in which such providers obtained Medicare provider numbers and billed the program extensively over the past several years:

-- Five clinical labs (to which Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the alleged submission of false claims. The labs' mode of operation was to bill Medicare large sums over 6 to 9 months; whenever a lab received inquiries from Medicare, it went out of business.

-- A wheelchair van service obtained a Medicare provider number as an ambulance service. The provider was not licensed by the state as an ambulance service nor did the provider have the equipment required by Medicare to qualify as an ambulance service. Over 16 months, on behalf of just one beneficiary, the van service billed Medicare $62,000 for 240 ambulance trips--about 1 trip every 2 days at nearly $260 per trip.

-- A therapy company added $170,000 to its Medicare reimbursements over a 6-month period, while providing no additional services, by creating a "paper organization" with no space or employees. The company simply reorganized its nursing home and therapy businesses so that a large portion of its total administrative costs could be allocated to Medicare.

-- A medical supply company serving nursing facility patients obtained more than 20 different Medicare provider numbers for companies that it controlled. The companies, all in the same state, were nothing more than shells that allowed the supplier to spread its billings over numerous provider numbers to avoid detection of its overbillings.

The conditions of program participation for Medicare providers range from stringent to minimal, according to the type of service or supply provided. For most provider categories, these conditions are established by statute.[7]

-- For some professionals, such as physicians, state licensure is required. Licensing boards typically perform background checks on the applicant's medical education, disciplinary actions, and related information.[8] However, states are slow to take action to penalize health care providers that engage in abusive billing practices.

-- Institutional providers (such as hospitals, clinics, home health agencies, and rehabilitation agencies) are surveyed and certified by state agencies as meeting Medicare requirements (and perhaps additional state conditions). However, there are many ways in which these precautions prove inadequate.

-- Nonmedical providers, such as suppliers of medical equipment, have historically been subject to few such provisions. Even though HCFA has recently taken steps to make improvements in this area, in some respects the requirements remain superficial. The National Supplier Clearinghouse was created to issue supplier numbers to providers desiring to submit claims for durable medical equipment, prosthetics, orthotics, and supplies. To apply for a supplier number, the provider must complete a detailed application. Because of privacy concerns, however, the Clearinghouse cannot verify the accuracy of two important items on these applications--social security and tax identification numbers. Also, the Clearinghouse does not routinely perform background checks on the owners or verify that supplier facilities really exist.

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[7]While the Secretary of HHS may impose additional requirements--and has done so in some instances--these must relate directly to patients' health or safety. See, for example, 42 U.S.C. 1395x(e)(9) for hospitals and 1395x(o)(6) for home health agencies.

[8]This is done using sources such as the American Medical Association profile, kept on all licensed physicians; the Federation of State Medical Boards' data bank; and the National Practitioners Data Bank.

EFFORTS TO PENALIZE WRONGDOERS
LARGELY INEFFECTIVE AS DETERRENTS

Currently, providers who defraud or otherwise abuse health care payers have little chance of being prosecuted or having to repay fraudulently obtained money. Although administrative and legal tools are available to Medicare,[9] few cases are pursued. Even when they are, many are settled without conviction, penalties are often light, and providers frequently continue in business. These are characteristics of health care fraud (and of white collar crime in general) and are not confined to Medicare.

Our review of Medicaid prescription drug fraud cases illustrates problems that are typical of health care fraud prosecution--the consequences for the convicted wrongdoer are often nominal. We found that few providers went to prison, and few had their licenses suspended or revoked. In many cases, convicted individuals or organizations resurfaced as health care providers serving Medicaid patients. In more than one half the cases reviewed, assessed restitution amounts were $5,000 or less. In one instance where a provider was assessed $220,000 for restitution, Medicaid recovered only $4,000. In a New York case in which only $50,000 of a $300,000 assessment was collected, eventual repayment of the remainder was contingent upon the owner's success in selling his pharmacy and the building that houses it. Opportunities exist for convicted owners to avoid repayment by various actions, including hiding assets under other names, transferring funds overseas, or declaring bankruptcy.[10]

Moreover, our reviews in Medicare have shown that often suspicious providers either are not or cannot be adequately pursued. We have found the following:

-- In some cases providers are asked to repay only nominal amounts of the estimated overpayments made by Medicare. To illustrate, a psychiatrist who in 1993 received about $440,000 in Medicare payments was submitting questionable bills. The Medicare contractor selected 15 of the psychiatrist's patients as a sample, reviewed their claims, and found that 75 percent were overstated by a total of about $5,700 due to miscoding or misrepresentation. Rather than projecting the error rate of

[9]For example, 42 U.S.C. 1320a-7, 1320a-7a, and 1320a-7b authorize exclusion from Medicare, civil monetary, and criminal penalties, respectively.

[10]Medicare and Medicaid overpayments once had priority in bankruptcy cases, but this was eliminated by the Bankruptcy Reform Act of 1978 (P.L. 95-598). The HHS Office of Inspector General, in a May 1992 report, recommended that HCFA seek a legislative change to restore this priority.

the sample to the total body of claims in order to estimate and recoup Medicare's likely loss, the contractor requested recoupment of only the $5,700, sent the psychiatrist an educational letter,[11] and closed the case.

-- In many cases providers submitting improbable claims are not reviewed. For example, in an ongoing assignment, we asked the Medicare contractor to obtain and review the medical records supporting 85 high-dollar medical supply claims. These included supply claims for a month in excess of $17,000 for some patients. In 45 percent of the cases (totaling almost $500,000), the providers did not submit the supporting medical records and had the claims denied. The contractor does not routinely follow up in cases where a provider does not submit requested documentation to ascertain why and whether documentation is available for the provider's other claims.

-- In some instances, legal rulings have precluded holding any individual or entity responsible for large, documented losses. Medicare contractors, for example, lack authority to assess overpayments using claims for care that physicians order from suppliers or laboratories. In one case, a contractor could not collect a $123,000 assessed overpayment from a laboratory affiliated with a scheme that defrauded Medicare. An administrative law judge ruled that, because the laboratory acted on physicians' orders, the laboratory could not be held liable for the costs billed. Nor could the physician, since his own claim was not in question.

PRIVATE SECTOR MANAGEMENT TECHNIQUES SUGGEST WAYS TO REMEDY PROGRAM WEAKNESSES

Medicare does not use (or in some cases use widely enough) private sector strategies to manage three of the factors that attract unscrupulous providers--excessive payment rates, inadequate safeguards over billing, and ineffective controls over providers. For example, private insurers and managed care organizations commonly use pricing strategies that take advantage of their buying power and of the competitive marketplace. These private payers also employ a range of techniques focusing on utilization: they examine tests and procedures for their appropriateness and their volume and they screen providers for their practice styles and quality of care. Some price and utilization strategies that could have applicability to Medicare are detailed in table 2.

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[11]Educational letters are sent by claims processing contractors to notify providers of billing errors. HCFA--seeking to maintain a good relationship with the physician community and to limit provider hassle--emphasizes education as an appropriate tool to get providers to bill correctly the first time.

Table 2: Commonly Used Private Sector Techniques and Applicability to Medicare

Private sector technique	Description	HCFA's current practice	HCFA explanation
Prompt reaction to market prices	Change prices quickly when paying more than competitively necessary	Prices generally not adjusted for declines in the price of product or service[a]	Pertinent statute generally permits appropriate adjustments only after completing a complex administrative process[b]
Negotiate with select providers	Selectively contract with providers to deliver certain services, such as hip replacements, at a specific price	Same payments generally made to any provider selected by beneficiary to provide services	Statute does not permit providers to be excluded unless they engage in certain prohibited practices[c]
Competitive bidding and negotiations	Set prices for services or service packages based on competitive process	Prices are set under complex formulas, but demonstration involving competitive procedures is proposed	Statute generally provides only for all area providers to be paid the same amount for service;[d] legislation specifically prohibited proposed demonstration[e]
Preferred provider network	Promote use of a network of selected providers meeting price, practice style, and quality criteria	Payments generally made to any provider selected by beneficiary to provide medical services	Statute guarantees beneficiary freedom to choose providers;[f] limited statutory authority to contract with managed care networks[g]
Preadmission review	Require prior approval of hospitalization for select procedures	No prior approval of hospitalizations for any procedures	No viable statutory authority for requiring prior approval; statute prohibits interference with practice of medicine[h]
Case management	Assist high-cost patients in selecting appropriate services efficiently	Assistance not provided to patients in selecting services efficiently	Statute prohibits interference with practice of medicine[i]
Contract with utilization review companies	Use companies specializing in utilization review to monitor and adjudicate claims	HCFA contracts with private entities--generally insurance companies--to process claims[j]	Statute provides no specific authority for contracting with utilization control organizations[k]

[a]Although 42 U.S.C. 1395u(b)(8) and (9) provide HCFA with authority to adjust payments when the established rates under a fee schedule are found to be inherently unreasonable, detailed procedures are mandated that include a lengthy notice and comment period.

[b]For example, 42 U.S.C. 1395m(a)(10)(B) provides HCFA with authority to adjust prices for durable medical equipment, excluding surgical dressings, but only after completion of a cumbersome administrative process. The one time this process was used, it took 3 years to complete.

[c]42 U.S.C. 1320a-7 provides for mandatory and permissive exclusion of providers who are, for example, convicted of certain program-related crimes.

[d]42 U.S.C. 1395f establishes conditions of and limitations on payment for services.

[e]In 1985, HCFA started the process to perform a demonstration of competitive bidding related to laboratory services, and it was set to begin in 1987. That year and in several subsequent years; however, provisions were included in the respective budget reconciliation acts specifically prohibiting its implementation. Eventually, HCFA abandoned plans for the demonstration, but has since requested authority to introduce such competitive bidding, without success.

[f]42 U.S.C. 1395a, the so-called freedom of choice provision, expressly provides that beneficiaries may obtain health services from any willing provider.

[g]42 U.S.C. 1395mm authorizes HCFA to contract with certain managed care entities to provide care to Medicare beneficiaries under prescribed circumstances.

[h]42 U.S.C. 1395.

[i]42 U.S.C. 1395.

[j]These companies may arrange for utilization review to be done under subcontract.

[k]42 U.S.C. 1395h provides detailed authorization for HCFA to contract with private entities without competitive procedures to handle part A claims, and 42 U.S.C. 1395u provides similar authority for part B claims.

For the most part, the pricing, utilization, and quality control mechanisms used in the private sector are not available to Medicare, constraining HCFA and its contractors from adopting similar measures.[12] For example, HCFA is generally unable to

-- negotiate with providers for discounts, promptly change prices to match those available in the market, or competitively bid prices for widely used items or services, such as pacemakers, intraocular lenses, cataract surgery, and wheelchairs. This has resulted in Medicare paying higher prices than other large payers.[13]

-- differentiate between providers who meet utilization, price, and quality standards and those who do not, and provide incentives to encourage beneficiaries to use the "preferred providers." This has hampered Medicare's ability to encourage beneficiaries to use providers meeting Medicare's standards.

-- use preadmission review or other utilization control practices to curb the excessive or unnecessary provision of expensive procedures, or use case management to coordinate and monitor high cost patients' multiple services and specialists. This has limited Medicare's ability to emphasize cost efficiency in its dealings with those suppliers, physicians, and institutions that habitually provide excessive services.

FACTORS LIMITING HCFA'S FLEXIBILITY

Three principles on which Medicare was founded--as interpreted by HCFA, providers, the courts, and the Congress--help explain why Medicare practices and private payer management techniques are dissimilar:

-- First, the government must not interfere in medical practice.[14] Medicare legislation essentially delegated many day-to-day administrative decisions to private insurers, to further lessen the risk of undue federal interference and to better ensure that Medicare would treat its beneficiaries no

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[12]42 U.S.C. 1395b-1 provides detailed authorization for experiments and demonstration projects related to incentives for economy while maintaining or improving quality in the provision of health care, but HCFA has found it of limited value.

[13]For further discussion of competitive bidding and negotiation strategies, see Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

[14]42 U.S.C. 1395.

differently than the privately insured.[15] The functions delegated include establishing policies on when claims for services are medically necessary--and today most such "medical policies" are still established by Medicare's private contractors.

-- Second, Medicare beneficiaries should be free to choose their own health care providers.[16] However, many of the private sector innovations credited with cost savings rely on managed care techniques that structure and constrain that choice. Staff- and group-model health maintenance organizations (HMO) explicitly restrict a patient's choice of health care providers (for example, to a set of plan-approved physicians and hospitals), while looser forms of managed care, such as preferred provider networks, give financial disincentives to the patient who chooses providers outside the plan-approved list. Although Medicare offers an HMO option to beneficiaries, HCFA has only limited statutory authority to pursue other managed care options.[17]

-- Third, as a public program, Medicare changes require public input and hence can be cumbersome and time-consuming. Past experience suggests that changes made by HCFA will typically be contested. Given the high stakes for providers, legal challenges are apt to be pursued vigorously by those who fear that program changes would result in their receiving lower payments. Although the ultimate outcome is always uncertain, litigation--whatever the outcome--can take years to resolve.[18]

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[15]42 U.S.C 1395h provides authority and detailed instructions for HCFA to contract with such entities to handle part A claims, while 42 U.S.C. 1395u provides similar guidance related to part B.

[16]42 U.S.C. 1395a, the so-called freedom of choice provision, expressly provides that beneficiaries may obtain health services from any willing provider.

[17]42 U.S.C. 1395mm authorizes HCFA to contract with certain managed care entities to provide care to Medicare beneficiaries under prescribed circumstances. Our analysis suggests, however, that under the current statutory prescriptions this has not harnessed the cost-saving potential of managed care. See our recent testimony, Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-94-174, May 24, 1995).

[18]For example, HCFA has in recent years made a more diligent effort to recover payments made mistakenly when other private insurers should have paid for a medical service. In 1989, the Congress permitted HCFA to begin performing a data match with the Internal Revenue Service to help identify such mistaken payments, with the result that millions have been recovered and millions more were

> Consequently, in considering cost-saving initiatives, HCFA must weigh the resulting expense and disruption as well as the risk of ultimate failure against anticipated savings. These circumstances foster HCFA's reluctance to act without specific statutory authority.[19]

These principles were consistent with the predominantly fee-for-service and unmanaged method by which health care was delivered and paid for three decades ago. Today, however, HCFA's capabilities to manage Medicare are misaligned with the state of the art in health care delivery and financing.

CONCLUSIONS

In conclusion, Medicare's vulnerability to exploitation can be summarized as follows:

-- Despite the current competitive health care market, Medicare often pays more than the market price for medical services and supplies.

-- Although payment of claims for services provided constitutes the program's chief administrative function, Medicare does not use available state-of-the art technology to screen claims for overcharging or overutilization.

-- Despite the increase in nonmedical providers billing for services and supplies, Medicare does little to scrutinize the legitimacy of providers billing the program.

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expected to be recovered. This effort was dealt a serious blow, however, when a federal court ruled in 1994 that HCFA is bound by the claims filing deadlines set by private insurers and may not recover from third-party administrators who handle claims processing for private insurers. Health Ins. Ass'n of America, Inc. v. Shalala, 23 F.3d 412 (D.C. Cir. 1994), cert. denied, 115 S.Ct. 1095 (1995). As a result, HCFA may be unable to recover millions in mistaken payments and may have to repay some funds previously recovered. See our testimony on this subject, Medicare's Secondary Payer Program: Actions Needed to Realize Savings (GAO/T-HEHS-95-92, Feb. 23, 1995).

[19]The courts are not the only forum where those questioning HCFA's exercise of its Medicare responsibilities might seek redress. In 1985, HCFA started the process to perform a demonstration of competitive bidding for laboratory services, and it was set to begin in 1987. That year and for several subsequent years, however, provisions were included in the respective budget reconciliation acts prohibiting its implementation. Eventually, HCFA abandoned plans for the demonstration, but has since requested authority to introduce competitive bidding without success.

-- Despite the availability of legal and administrative enforcement tools, few wrongdoers are convicted or otherwise penalized.

The problems facing Medicare confront private insurers as well, but they are armed with a larger and more versatile arsenal of health care management techniques than HCFA currently has. These techniques may not be wholly transferable to Medicare, but in general they offer a menu of options for devising ways to make Medicare more cost effective. Commercial contractors, which play a key role in administering Medicare, routinely employ management-of-care techniques and use state-of-the-art technology in their capacity as private insurers. If they were able to apply these techniques to Medicare, the program's weaknesses could be significantly remedied.

Given Medicare's vulnerabilities, a more modern approach tailored to the program would adopt the following three strategies:

1. Allow Medicare to price services and procedures more competitively. This could include streamlining processes required to revise excessive payment rates and competitively bidding and negotiating prices.

2. Enhance Medicare's antifraud and abuse efforts. This could include completing the modernization of Medicare's claims processing and information systems and expanding the use of state-of-the-art computerized controls.

3. Require providers to demonstrate their suitability as Medicare vendors before giving them unrestricted billing rights. This could include HCFA's establishment of preferred provider networks, development of more rigorous criteria for authorization to bill the program, and use of private entities to provide accreditation or certification.

Because these efforts are funded out of the government's discretionary appropriations, however, funding increases would necessitate spending cuts in other government programs. We have been recommending since May 1991 that the Congress consider extending the budget option available to the Internal Revenue Service under the Budget Enforcement Act of 1990. If a similar option was available to Medicare, HCFA would be able to provide its contractors with the necessary motivation to prevent or recover losses resulting from exploitative billings.

RELATED GAO PRODUCTS

Medicare: Adapting Private Sector Techniques Could Curb Losses to Fraud and Abuse (GAO/T-HEHS-95-211, July 19, 1995).

Medicare: Rapid Spending Growth Calls for More Prudent Purchasing (GAO/T-HEHS-95-193, June 28, 1995).

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/T-HEHS-95-157, May 16, 1995).

Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995).

Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T-HEHS-95-110, Mar. 22, 1995).

Medicare's Secondary Payer Program: Actions Needed to Realize Savings (GAO/T-HEHS-95-92, Feb. 23, 1995).

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75, Feb. 6, 1995).

High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).
(101364)

QUESTION (1) -- QUESTION FOR MS. BROWN, ET AL.

On page 15 of your prepared statement Ms. Brown, you refer to a mechanism to increase funding for Medicare and Medicaid anti-fraud efforts without increasing the deficit or further burdening taxpayers.

You state that under this concept, certain recoveries generated by health care anti-fraud activities would be deposited into a reinvestment fund with dollars available to fund additional enforcement activities. And you further state that restitution to the Medicare trust funds and to Medicaid would be made before any monies could be deposited into this new account.

In fact, the CBO testimony on page 10 also refers to such a mechanism which, in this case, is included in the proposed Administration bill and would be called the "HHS Fraud and Abuse Control Fund". I understand there is a similar provision contained in Senator Cohen's recently revised bill.

Let me just say that I have concerns that such a bounty hunter system would create an incentive for Federal investigators to pursue large civil penalties where they might otherwise not be appropriate in order to add to the trust fund.

In general, I find this concept troubling because, in fact, it may lead to unscrupulous anti-fraud activities by an over-zealous bureaucracy which is out to enhance its own mission.

I would appreciate your thoughts regarding my concerns and I would also welcome Mr. Owens' perspective.

To the best of my knowledge I'm not aware of any similar Federal mechanism, and I believe it may set the wrong precedent.

Question (1)

MS. JAGGAR: Perhaps the best way that I can respond to your concern is to refer you some correspondence we recently sent to Representative Barton, the Chairman of the Subcommittee on Oversight and Investigations, House Committee on Commerce. **[Cite correspondence]**

This correspondence discusses several different proposals to channel additional funds to program safeguard activities. Discussed proposals include the establishment of an HHS Fraud and Abuse Control Fund, the Medicare Benefit Quality Assurance Program, and two possible models for a statutory solution to the discretionary spending limits imposed by the Budget Enforcement Act of 1990.

In reference to your concern that the existence of an HHS Fraud and Abuse Control Fund might serve as an incentive to pursue large civil penalties where it might not be appropriate to do so, it is my understanding that deposits to the HHS Fraud and Abuse Control Fund would be limited to $2 million each year. Such a limit would appear to serve as somewhat of a disincentive to pursue large civil penalties just to increase the fund balance.

(3) -- QUESTION FOR MR. VAN de WATER WITH THE CBO AND MS. BROWN AND MS. JAGGAR IF YOU WISH TO COMMENT

Mr. Van de Water, you mention in your testimony that many of the elements of Medicare that have lead to excessive spending are embedded in the legislation which created the program thirty years ago.

Specifically you refer to the emphasis on unmanaged fee-for-service care and the cumbersome procedures required to revise certification requirements and payment rates.

As you know, 10 percent of Medicare beneficiaries are currently in a managed care arrangement and there appears to be growing support to modify current law so that more beneficiaries could take advantage of managed care services.

To what extent will allowing more beneficiaries in manage care help solve some of the fraud and abuse problems we see in the fee-for-service setting?

And I guess another way of looking at this is whether you see aspects of manage care that may be rip for new types of fraudulent activity?

Question (3)

MS. JAGGAR: I do not think the movement of more and more Medicare beneficiaries to some type of managed care will necessarily solve the fraud and abuse problems we see in the fee-for-service setting. It is important to keep in mind that you can have fee-for-service care in a managed care setting. This can occur, for example, when a managed care plan pays a clinical laboratory to perform tests on a fee basis. As long as you have fee-for-service care, you will likely have fraud and abuse.

Rather than solving fraud and abuse problems, the movement to managed care increases the possibilities of fraud and abuse. To protect scarce taxpayer dollars, it is imperative that we be vigilant in guarding against the types of fraud and abuse that we have in the fee-for-service system with its incentive to overserve. At the same time, however, we must also guard against the enrollment, financial, and marketing abuses that can accompany managed care and its incentive to underserve.

PREPARED STATEMENT OF CHARLES L. OWENS

GOOD MORNING MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE. IT IS MY PLEASURE TO BE HERE TODAY REPRESENTING THE FEDERAL BUREAU OF INVESTIGATION AS YOUR COMMITTEE EXAMINES THE ISSUE OF MEDICARE FRAUD.

AS YOU KNOW, HEALTH CARE FRAUD AND ABUSE MAY ACCOUNT FOR AS MUCH AS 10 PER CENT OF ALL HEALTH CARE EXPENDITURES, OR AS MUCH AS $100 BILLION THIS YEAR.

BEFORE I ADDRESS SOME OF THE PROBLEMS THE FBI HAS ENCOUNTERED, I WOULD LIKE TO EMPHASIZE THAT WITHOUT QUESTION, A LARGE PERCENTAGE OF HEALTH CARE PROFESSIONALS AND BUSINESSES PROVIDE QUALITY MEDICAL TREATMENT AND BILL HONESTLY FOR THEIR SERVICES. UNFORTUNATELY, WE ARE SEEING A RISE IN THE INFILTRATION OF THE HEALTH CARE SYSTEM BY CORRUPT INDIVIDUALS WHO VICTIMIZE CITIZENS WITH HEALTH CARE FRAUD SCHEMES SET IN MOTION SOLELY BY GREED.

I WANT TO MAKE THREE POINTS TODAY DURING MY PREPARED REMARKS:

FIRST, THE FBI IS SEEING EXTRAORDINARY GROWTH IN THE NUMBERS OF INVESTIGATIONS UNDERWAY.

SECOND, THE FBI HAS A STRATEGY FOR ADDRESSING THE HEALTH CARE FRAUD PROBLEM.

THIRD, AS ILLUSTRATED THROUGH CASE STUDIES, HEALTH CARE FRAUD IS A SERIOUS CRIME PROBLEM THAT SEVERELY IMPACTS THE FINANCIAL STRUCTURE OF OUR NATION'S HEALTH CARE SYSTEM.

GROWTH IN HEALTH CARE FRAUD INVESTIGATIONS

FBI FIELD OFFICES HAVE REPORTED DRAMATIC INCREASES IN HEALTH CARE CRIME. FOR EXAMPLE, IN 1991 THERE WERE 365 HEALTH CARE FRAUD CASES UNDER INVESTIGATION BY THE FBI. TODAY, THAT NUMBER IS APPROACHING 2000. HEALTH CARE FRAUD EXISTS IN ALL FIFTY STATES AND IN MOST MAJOR CITIES. EACH OF THE FBI'S 56 FIELD OFFICES HAS AT LEAST TWO PENDING HEALTH CARE FRAUD INVESTIGATIONS. UNFORTUNATELY, MOST OF OUR FIELD OFFICES REPORT AN INCREASINGLY LARGE NUMBER OF UNADDRESSED CASES. HEALTH CARE FRAUD HAS NOT BEEN INVESTIGATED AND PROSECUTED AS EFFICIENTLY AND EFFECTIVELY AS WE WOULD LIKE.

OUR STRATEGY FOR ADDRESSING HEALTH CARE FRAUD

TO HEALTH CARE FRAUD WHEN WE ARE FACING A CRIME PROBLEM WHICH AFFECTS ALL PARTS OF OUR COUNTRY AND ALL SEGMENTS OF OUR ECONOMY. DURING THE EIGHTIES, THE COUNTRY SUFFERED THROUGH MAJOR CRIME PROBLEMS INCLUDING ILLICIT DRUG TRAFFICKING, THE SAVINGS AND LOAN CRISIS, DEFENSE PROCUREMENT CORRUPTION, ORGANIZED CRIME SYNDICATES, SECURITIES SCANDALS AND VIOLENT CRIMINAL GANGS. HEALTH CARE FRAUD IS NO LESS A SERIOUS CRIME PROBLEM.

THEREFORE, THE FBI IS DEVELOPING A NATIONAL STRATEGY DESIGNED TO PRODUCE A LONG-TERM, FAR REACHING POSITIVE IMPACT. THE SIX ELEMENTS OF THE FBI'S NATIONAL HEALTH CARE FRAUD STRATEGY ARE AS FOLLOWS:

- FIRST, THE FBI IS DEDICATED TO A TEAM APPROACH IN ADDRESSING HEALTH CARE FRAUD. MOST OF OUR FIELD OFFICES ARE ALREADY INVOLVED IN HEALTH CARE FRAUD TASK FORCES OR WORKING GROUPS. A GREAT MANY OF OUR INVESTIGATIONS ARE JOINTLY INVESTIGATED WITH AGENTS FROM THE INSPECTOR GENERAL'S (IG) OFFICE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS). RECENTLY THE FBI AND THE IG'S OFFICE INITIATED AN EXCHANGE OF HEADQUARTERS AGENTS TO FOSTER THIS COOPERATIVE EFFORT.

o THE SECOND ELEMENT OF THE NATIONAL STRATEGY IS THE REGULAR UTILIZATION OF SOPHISTICATED INVESTIGATIVE TECHNIQUES. FOR EXAMPLE, A RECENTLY CONCLUDED NATIONAL INITIATIVE TARGETING STAGED AUTOMOBILE ACCIDENTS AND RELATED CASUALTY AND HEALTH INSURANCE FRAUD MADE USE OF UNDERCOVER TECHNIQUES. OVER 500 INDIVIDUALS WERE ARRESTED OR INDICTED NATIONWIDE AND OVER 300 HAVE ALREADY PLED GUILTY.

o THE THIRD ELEMENT IS THE USE OF ASSET FORFEITURE AND MONEY LAUNDERING STATUTES. THESE STATUTES HAVE PROVEN TO BE USEFUL TOOLS IN OTHER INVESTIGATIVE PROGRAMS AND SHOULD PROVE LIKEWISE IN HEALTH CARE FRAUD.

o THE FOURTH ELEMENT IS AN EFFECTIVE BLEND OF CRIMINAL, CIVIL AND ADMINISTRATIVE ENFORCEMENT. THE DEPARTMENT OF JUSTICE HAD EIGHT HUNDRED AND NINETEEN CIVIL HEALTH CARE FRAUD MATTERS PENDING AT THE END OF FISCAL 1994, A 203 PERCENT INCREASE OVER THE 270 PENDING IN FISCAL YEAR 1992. THE FBI HAS EXPANDED ITS INVESTIGATIVE EFFORT IN THESE MATTERS.

o THE FIFTH ELEMENT OF THE NATIONAL STRATEGY INVOLVES THE FORMULATION OF WHAT THE FBI CALLS "NATIONAL INITIATIVES." NATIONAL INITIATIVES ARE INVESTIGATIONS HAVING A NATIONAL SCOPE. WE CREATE THESE

THE NATION CANNOT AFFORD A PIECEMEAL APPROACH

INITIATIVES BY TWO DIFFERENT METHODS. THE FIRST METHOD IS TO CONSOLIDATE SIMILAR CASES WHICH ARE BEING INVESTIGATED BY SEVERAL FBI FIELD OFFICES, SUCH AS THE PREVIOUSLY MENTIONED INITIATIVE INVOLVING STAGED AUTOMOBILE ACCIDENTS. THE OTHER TYPE OF INITIATIVE CONSISTS OF LARGE-SCALE INVESTIGATIONS OF NATIONWIDE HEALTH CARE PROVIDERS WITH FACILITIES ACROSS THE NATION. AN EXAMPLE OF THIS TYPE OF INITIATIVE IS THE INVESTIGATION OF NATIONAL MEDICAL ENTERPRISES WHICH OWNED PSYCHIATRIC HOSPITALS LOCATED IN NUMEROUS STATES.

- THE FINAL ELEMENT IS THE IDENTIFICATION OF TARGET AREAS. FRAUD IS SPREAD ACROSS ALL SEGMENTS OF THE HEALTH CARE INDUSTRY AND ALL AREAS OF THE COUNTRY. HOWEVER, SOME AREAS ARE MORE SEVERELY IMPACTED BY FRAUD THAN OTHERS, AND SOME AREAS ARE MORE IMPORTANT BECAUSE A GREATER AMOUNT OF MONEY IS SPENT AND WASTED IN THE TARGET AREAS THERE. TAKE THE STATE OF FLORIDA, FOR INSTANCE, WHERE TEN PERCENT OF OUR MEDICARE DOLLARS ARE SPENT. IN DADE AND BROWARD COUNTIES ALONE HALF OF THAT AMOUNT, OR FIVE PERCENT OF THE NATIONS TOTAL IS EXPENDED. OUR MIAMI FIELD OFFICE RECENTLY REPORTED THAT THEY HAD 270 UNADDRESSED HEALTH CARE FRAUD CASES. IN RESPONSE TO THAT BACKLOG OF UNADDRESSED WORK, FBI HEADQUARTERS AUTHORIZED MIAMI

TO ESTABLISH A SECOND HEALTH CARE FRAUD SQUAD TO INVESTIGATE NOTHING BUT HEALTH CARE FRAUD MATTERS.

RECENT CASE STUDIES

FINALLY, I WANT TO TELL YOU ABOUT SOME OF THE CASES THE FBI HAS WORKED THAT ILLUSTRATES THE SERIOUSNESS OF HEALTH CARE FRAUD. IN A RECENT INVESTIGATION, AN ELDERLY LICENSED PHYSICIAN PARTICIPATED IN A MEDICARE FRAUD SCHEME BY SIGNING BLANK DIAGNOSTIC TEST ORDERS AND BLANK PRESCRIPTIONS WHICH ENABLED UNLICENSED PERSONS INVOLVED IN THIS SCHEME TO "EXAMINE" PATIENTS, ORDER TESTS, AND PRESCRIBE MEDICATIONS.

ALL OF THESE BILLINGS WERE SUBMITTED TO MEDICARE. THE DEFENDANT'S CLINIC ALSO PAID "RECRUITERS" KICKBACKS OF UP TO $150 FOR EACH MEDICARE PATIENT DELIVERED. THIS SCAM IS BELIEVED TO HAVE COST MEDICARE $3.3 MILLION IN SERVICES NOT PROVIDED OR NOT NECESSARY.

IN ANOTHER INVESTIGATION, IT WAS LEARNED THAT A NUMBER OF COMPANIES IN THE BUSINESS OF DISTRIBUTING LIQUID NUTRITIONAL SUPPLEMENTS WERE ALSO ESTABLISHED AS MEDICARE BILLING COMPANIES. THESE NUTRITIONAL SUPPLEMENTS DISTRIBUTORS DEVISED A SCHEME TO DEFRAUD MEDICARE BY HIRING "RECRUITERS" WHO WOULD SEEK OUT THE

ELDERLY COMMUNITY AND OFFER THESE SENIOR CITIZENS "FREE MEDICAL MILK." ONCE THESE UNSUSPECTING SENIORS BECOME INTERESTED IN THE MILK SUPPLEMENT THEY WERE SIGNED UP BY THE RECRUITERS AS "NEW PATIENTS" AND MEDICARE WOULD THEN BE BILLED. IN LESS THAN TWO YEARS, THESE COMPANIES BILLED MEDICARE FOR OVER $14 MILLION. OF THOSE PATIENTS INTERVIEWED BY THE FBI, NONE WERE QUALIFIED FOR OR NEEDED TUBULAR FEEDING REQUIRED BY MEDICARE TO PAY FOR SUCH A FOOD SUPPLEMENT.

THE ATTORNEY GENERAL HAS NAMED HEALTH CARE FRAUD ENFORCEMENT HER NUMBER TWO INITIATIVE, BEHIND VIOLENT CRIME. HOWEVER, DESPITE OUR BEST EFFORTS, HEALTH CARE FRAUD WILL CONTINUE.

THERE ARE WAYS THAT CONGRESS CAN ASSIST THE FBI AND THOSE OTHER AGENCIES CHARGED WITH INVESTIGATING AND PROSECUTING THOSE INDIVIDUALS WHO PREY ON OUR HEALTH CARE SYSTEM.

WE ENDORSE EFFORTS BY THIS CONGRESS TO STRENGTHEN CRIMINAL, CIVIL, AND ADMINISTRATIVE REMEDIES FOR HEALTH CARE FRAUD. A NUMBER OF LEGAL WEAPONS ARE NOT PRESENTLY AVAILABLE TO US. FOR EXAMPLE, THERE IS NOT A SPECIFIC HEALTH CARE FRAUD OFFENSE, THE DEPARTMENT OF JUSTICE DOES NOT HAVE ADMINISTRATIVE SUBPOENA AUTHORITY IN HEALTH CARE FRAUD INVESTIGATIONS, AND

CERTAIN HEALTH CARE FRAUD SCHEMES ARE NOT COVERED UNDER MONEY LAUNDERING STATUTES. IN ADDITION, THE CURRENT KICKBACK STATUTE COVERS ONLY MEDICARE AND MEDICAID. IT DOES NOT COVER OTHER GOVERNMENT PROGRAMS, NOR INCLUDE A CIVIL ANTI-KICKBACK PROVISION. THE CURRENT FEDERAL STATUTE NEEDS TO BE EXPANDED AND WE WILL WORK WITH THE COMMITTEE TO EXPLORE THE MOST EFFECTIVE WAYS TO ACCOMPLISH THIS. THERE SHOULD BE AN EXPLICIT CRIMINAL AND CIVIL BAR ON SUCH KICKBACKS. THESE AND OTHER MEASURES WOULD GIVE US ADDITIONAL TOOLS NEEDED TO COMBAT THIS ESCALATING CRIME PROBLEM.

MR. CHAIRMAN, THIS CONCLUDES MY PREPARED REMARKS. I WILL BE HAPPY TO ANSWER ANY QUESTIONS THAT YOU OR OTHER MEMBERS MAY WISH TO ASK.

RESPONSE TO SENATOR HATCH RE TESTIMONY OF CHARLES L. OWENS
CHIEF, FINANCIAL CRIMES SECTION, FEDERAL BUREAU OF INVESTIGATION

Question: Explain in detail why health care fraud crimes are difficult to investigate and prosecute.

Response:

One of the questions which you expressed was why health care fraud crimes are difficult to investigate and prosecute. Health care fraud investigations are document as well as labor intensive. They are also cases which are extremely sensitive involving complex financial and medical issues. As an example, in the joint investigation of a national corporation up to twenty FBI Agents worked full-time for two years to bring the first part of this case to a successful conclusion. In the same investigation, the FBI, Health and Human Services- Inspector General,Defense Criminal Investigative Service, Postal Inspection Service, Internal Revenue Service and State Medicaid Units used 600 Agents to coordinate and execute nationwide searches of company hospitals and corporate offices.

Medical fraud investigations demand that agents not only are experienced criminal investigators, but know diagnosis and treatment codes and their reimbursement schedules. To complicate cases even further, the Health Care Financing Administration (HCFA), Medicaid, the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), the Federal Employees Health Program (FEHP) and approximately 1,800 private insurers reimburse providers using different rates. During each investigation an investigator must analyze those issues to determine which federal, or in some cases, state laws have been violated. Complex cases involving hospitals, nursing homes and home health care agencies frequently require the full-time assignment of an agent for a year or longer.

To frustrate investigators even further, health care offenders today are not only American citizens, but embrace many nationalities, speaking Russian, Spanish, Vietnamese, Armenian, Bengali, Tagalog, and Arabic. Language barriers provide a greater complication to already complex and labor intensive investigations.

When presenting health care fraud cases for prosecution it becomes apparent that there is a wide disparity among both statutes and penalties pertaining to the same health care related crimes. More specifically, health care professionals who commit fraudulent acts often spread their activity among a number of insurance plans in order to limit drawing attention to their scheme. If they submit false claims to Medicare they violate Title 42, U.S. Code Sections 1320 (7a-g). If they submit false claims to private insurers, they will likely violate either the mail or wire fraud statues. False statements to CHAMPUS or the FEHP could possibly violate federal false statement or false claims statutes. As you can see from this illustration, there is a prosecutive stumbling block because these statutes have different penalties even though the scheme is the same.

In addition, present kickback statutes apply only to the Medicare and Medicaid programs. The payment of kickbacks for the delivery of medical services or items for the FEHP, CHAMPUS, other government programs, and private insurance carriers is not illegal. During the National Medical Enterprises (NME) investigation, this company pled guilty to paying only kickbacks for services provided to Medicare patients even though Medicare amounted to a small percentage of insurance revenues by NME. Billings to CHAMPUS and FEHP were many times greater than those to Medicare and Medicaid. In fact, since the reimbursements by Medicare and Medicaid were substantially less than private insurers and other government programs, NME marketed their services towards attracting patients to their facilities that paid at higher reimbursement rates.

Question: What is the FBI's perspective on the " HHS Fraud and Abuse Control Fund" ?

Response:

The Department of Justice, including the Federal Bureau of Investigation, supports the general concept of the establishment of a Health Care Fraud and Abuse Control Account as a source of supplemental funding for health care fraud enforcement work. Our efforts would certainly benefit from an increase in resources. The Department of Justice would welcome the opportunity to offer suggestions regarding the creation and operation of such an account.

As noted, the creation of such an account has the potential to be perceived by the American public and medical profession as a bounty hunter system which federal agencies maintain to fund their own enforcement activities. Strict oversight of this account by the Attorney General and the Secretary, Department of Health and Human Services, with annual reports to Congress on the amount of revenue which is generated and disbursed by the account in each fiscal year should dispel any concerns.

PREPARED STATEMENT OF PAUL N. VAN DE WATER

The budget resolution assumes that the Congress will take actions to reduce the growth of Medicare spending by $270 billion over the 1996-2002 period. As the Congress considers alternative approaches to meeting that target, it is repeatedly confronted with claims that fraud, waste, and abuse are major factors contributing to current levels of outlays and rates of growth in Medicare. Both the general public and many Members of Congress feel that reducing or eliminating illegal or inappropriate behavior on the part of some health care providers would in turn reduce or eliminate the need for making more difficult decisions about how to limit the rate of growth in federal health spending.

Evaluating proposals to reduce fraud, waste, and abuse in Medicare involves addressing three questions. First, what kinds of spending are embodied in the terms fraud, waste, and abuse? Second, what steps could be taken to reduce fraudulent or wasteful spending and improve the integrity of the Medicare program? Finally, how would the Congressional Budget Office (CBO) estimate the savings that might stem from such efforts?

DEFINING FRAUD, WASTE, AND ABUSE

The terms waste, fraud, and abuse are often raised in discussions of federal health spending without being clearly defined or distinguished from the spending for health services that Medicare is intended to cover. One way to think of those issues is to

place all of the activities for which Medicare reimburses providers on a spectrum. At one end of the spectrum are activities that are unmistakably illegal. For example, a health care provider--or, more accurately, nonprovider--who deliberately bills Medicare for services that have not been rendered to a covered beneficiary is clearly engaging in a fraudulent activity. At the other end of the spectrum are the medically necessary, competently performed, and fairly priced health care services for which Medicare is intended to pay.

Although those poles are relatively easy to identify, there is ample room between them. Moreover, no clear line separates abusive activities from fraud. One definition that has been put forth distinguishes abusive activities as those that are not illegal but that violate the intent of the program. That definition, however, offers little guidance in practice. Consider, for example, whether the following examples should be described as abuse:

- A technician mistakenly takes an X-ray of a patient's left leg, then takes a second X-ray when he discovers his error. The hospital bills Medicare for both X-rays.

- A physician admits a patient to a hospital to ensure that drugs are paid for that would not otherwise be covered under Medicare.

- To offset lower fees paid by Medicare, a physician begins recommending follow-up office visits for certain conditions that previously did not warrant such visits.

- A managed care plan markets itself in a way that attracts relatively healthy beneficiaries, thus increasing its profits by reducing the costs of care below those envisioned in the risk-contract reimbursement formula.

Depending on one's perspective, those activities might or might not be characterized as abusive. A definitive characterization, however, would require an understanding of both Congressional intent--that is, knowing the objective of the legislation that permitted (or prohibited) a particular activity--as well as the intent of providers or beneficiaries and the circumstances surrounding their actions. Certainly, some Medicare spending reflects abusive activities; how much is considerably less clear.

Distinguishing between spending that is wasteful and spending that is appropriate is even harder. Among the factors making that determination problematic are the uncertainties of medical science and the lack of financial incentives to limit spending.

Medicare pays for services whose ultimate success is often unknown at the individual level. For example, even the most appropriate use and careful application of diagnostic tests will often rule out a particular illness rather than confirm its presence. In addition, treating a particular illness often allows several approaches, whose costs may vary substantially. Differences in approach may reflect lack of scientific consensus or simply differences in patterns of practice among providers. Studies show that the incidence of many medical procedures varies far more among regions of the country than can be explained by differences in the characteristics of the population of patients.

Advances in medical science may reduce, but will probably never eliminate, uncertainties in diagnosis and treatment. Although negative test results or failed treatments may seem wasteful after the fact, that vantage point is not necessarily the appropriate one from which to assess the value of the services. Similarly, one may expect medical approaches to particular illnesses to become more similar over time as the most successful methods become apparent. Efforts to reduce spending by forcing that convergence to happen more quickly may stifle innovation.

Perhaps more important than the potential waste from the technical aspects of medical care is the institutional environment in which Medicare beneficiaries and health care providers meet. In markets where consumers are well-informed and pay the full costs of purchasing goods and services themselves, economists would

generally not view waste as a relevant issue because people can be presumed to purchase only goods and services that are of value to them. That presumption, however, is much less valid for Medicare. Beneficiaries have had little incentive to concern themselves with costs because they may pay little or nothing at the margin for additional services. Moreover, consumers of health care are often ill-equipped to assess the risks and benefits of alternative therapeutic approaches. The financial incentives faced by health care providers in the fee-for-service sector also encourage the provision of more rather than fewer services.

Medicare spending can be reduced by changing the financial incentives given to beneficiaries and providers. For example, increasing the exposure of beneficiaries to the costs of health care at the margin could make them more cost-conscious and potentially reduce spending. As long as most Medicare beneficiaries have first-dollar coverage through the Medicaid program or through private medigap insurance, however, reducing health spending by this route is difficult. Certain types of managed care could also reduce the use of health care services--in this case by altering the incentives of providers. How much of the reduction would occur through cutting unnecessary services is less clear.

IMPROVING PROGRAM INTEGRITY

Since 1990, the General Accounting Office (GAO) has made a special effort to review and report on federal programs especially vulnerable to fraud, waste, abuse, and mismanagement. Both Medicare and Medicaid are included in that group of programs. A number of GAO reports have been released that describe specific problems or that suggest ways the Health Care Financing Administration (HCFA) might more effectively reduce the potential for fraud and abuse in its programs.

GAO has cited several factors that make it difficult to ensure the integrity of the Medicare program. One of those is the continued emphasis on unmanaged fee-for-service care, which generates incentives for providers to bill for unnecessary care. Currently, only about 9 percent of Medicare beneficiaries are enrolled in health maintenance organizations (HMOs). GAO notes, however, that managed care plans offer the potential for a different kind of abuse, which is to provide inadequate services. In the fee-for-service sector, problems include:

- *Weak controls for detecting questionable billing practices.* All Medicare bills are screened for consistency and completeness as part of the initial processing

of claims. Even very high volumes of services to individual patients or by individual providers do not necessarily trigger further review before payment. Currently, less than 5 percent of Medicare claims are reviewed.

- *Inadequate checks on the legitimacy of those billing the program.* Medicare lacks stringent requirements for issuing billing numbers to certain providers. In some cases, phantom companies with only a post office box number have qualified to bill the Medicare program. Also, surveys of providers are too infrequent to ensure their continued compliance with Medicare's conditions of participation.

- *Little chance of being prosecuted or penalized.* The weak controls on billing mentioned above make it unlikely that inappropriate claims will be detected, but when they are detected recovery is uncertain. Penalties are often light, large penalties are difficult to collect, and providers often continue to bill Medicare.

HCFA believes that investment in anti-fraud and abuse activities yields a high return, paying for itself many times over by reducing spending for Medicare benefits. The Congress has established other objectives as well, however, which conflict with the objective of deterring fraud and abuse. Two of those other objectives are to ensure reasonably prompt payment to providers and to keep down the costs of

processing claims. Currently, the same conflicting objectives are set for Medicare's contractors. As a result, efforts to detect fraud and abuse may be curtailed because they would increase the costs of processing claims.

It is unrealistic to think that fraud and abuse could be eliminated from Medicare, but their extent could be reduced. HCFA and other federal agencies already have a number of initiatives in place and others in the planning stages that are intended to enhance the integrity of the Medicare program. A number of initiatives are under way at HCFA:

- HCFA is establishing a Medicare Transaction System for processing all Medicare claims. By 1999, that centralized system will replace the 10 different systems now used by Medicare contractors and will integrate claims from Part A and Part B. All claims for a given beneficiary or provider will be in the system, thereby simplifying claims processing and improving the agency's ability to detect inappropriate billings.

- HCFA is running a demonstration program in four states, intended to determine whether simplified and more comprehensive mailings of EOMB (explanation of Medicare benefits) statements to beneficiaries can be used as a cost-effective check on inappropriate billings. Currently, Medicare enrollees

do not receive notices when benefits are paid on their behalf for services that do not require patient cost sharing (primarily home health and laboratory services).

- Operation Restore Trust is a HCFA demonstration in five states targeted toward nursing facilities, home health agencies, and suppliers of durable medical equipment. The demonstration (which builds on an earlier demonstration limited to south Florida) is intended to identify and correct processes in the Medicare and Medicaid programs that make them unnecessarily vulnerable to fraud and abuse. One prominent feature of the demonstration is coordination among federal, state, and private health plans--an important factor because fraudulent practices are rarely targeted toward only one insurer.

- HCFA is also examining ways to improve the provider enrollment process so that fraudulent or unqualified providers are unable to bill Medicare. Some improved procedures have already been put in place for suppliers of durable medical equipment through the National Supplier Clearinghouse, which contains nationwide information on those suppliers. Clearly, HCFA needs stronger requirements for granting Medicare participation, as well as periodic resurveys of participating providers to ensure that they remain in compliance. But HCFA is still reviewing possible corrective actions to take in those areas.

- HCFA has taken steps to focus resources better on fraud and abuse. One individual now serves as the focal point for those activities, reporting directly to the HCFA Administrator. Further, the agency recently established special units at each contractor's site to develop and pursue fraud cases in Medicare. Previously, such activities were collateral duties for contractors, and those duties were given low priority.

The Department of Health and Human Services (HHS) has drafted the Medicare and Medicaid Payment Integrity Act of 1995, which is intended to increase its capacity to combat fraud and abuse in Medicare and Medicaid. One provision would establish an HHS Fraud and Abuse Control Fund, which would finance further investigations of fraud and abuse from funds collected from previous settlements involving Medicare and Medicaid claims, after reimbursing the programs for their losses. A second provision would provide a dependable, long-term funding source from the Medicare trust funds to be used for initiatives to improve the integrity of the Medicare program. That funding would support specialized fraud and abuse units with multiyear contracts. Under current law, funding for activities to improve program integrity is subject to the annual appropriation process and to the statutory limits on discretionary appropriations. Because of the resulting instability in funding, HCFA has found it difficult to invest in developing strategies to control fraud and abuse, nor have Medicare contractors had much incentive to hire and train qualified auditors and investigators.

The Inspector General of the Department of Health and Human Services has been giving greater emphasis to investigating suspected instances of fraud in Medicare and Medicaid. The Inspector General estimates that each dollar spent on these investigations has generated about $7 in recoveries or fines on average for 1990 through 1994. In addition, the Attorney General has said that deterring health care fraud and abuse is the number two priority at the Department of Justice, right after deterring violent crime.

ISSUES RELATING TO BUDGET SCOREKEEPING

Although many proposals to reduce fraud, waste, or abuse in Medicare pose challenges for budget estimators, the difficulty of preparing estimates is not a bar to using such proposals as part of a reconciliation package. Even if data are scanty, CBO will provide the best possible estimate using the information that is available. Congressional scorekeeping rules, however, do prevent CBO from assigning savings to certain proposals for increasing activities to safeguard payments. The final portion of this statement will illustrate the kinds of proposals to which CBO would assign savings and the much smaller set of proposals to which savings could not be credited.

Changes in the Structure of Benefits and Administration

Many of the elements of Medicare that lead to excessive spending are embedded in the legislation establishing the program--particularly, the emphasis on unmanaged fee-for-service care and the cumbersome procedures required to revise certification requirements and payment rates. Legislation modifying those elements of the program could result in quantifiable savings.

For example, the General Accounting Office suggests that Medicare be allowed to price services and procedures more competitively. According to GAO, that recommendation could encompass streamlining processes required to revise excessive payment rates, allowing competitive bidding for services, and negotiating prices. CBO has prepared estimates for many specific proposals of this type, such as limiting payments to physicians in hospitals whose costs far exceed the national median, bundling payment for post-acute care services into payments to hospitals, requiring competitive bidding for certain durable medical equipment and diagnostic tests, establishing payment limits for outpatient department services not covered under current cost limits, and revising cost limits for home health services and skilled nursing facilities.

Another GAO recommendation is to require health care providers to demonstrate their suitability as a Medicare vendor before giving them unrestricted

billing rights. Under that rubric GAO mentions establishing preferred provider networks, developing more rigorous criteria for authorization to bill the program, and using private entities to provide accreditation or certification. CBO has already prepared an estimate for a proposal to establish a preferred provider option for both Parts A and B of Medicare.

Those examples are but a few of the ways in which this Committee might achieve real savings by improving the management of the Medicare program. The Congressional Budget Office will continue to work closely with your staff to provide estimates of those or similar provisions that the Committee may wish to consider.

Payment Safeguard Activities

In a few situations, however, Congressional scorekeeping rules preclude CBO from assigning savings to proposals to improve the management of federal programs, including Medicare. Even before the passage of the Congressional Budget Act and the creation of CBO, Congressional scorekeeping employed the principle that changes in discretionary appropriations for administrative activities do not produce scorable savings or costs in direct spending programs or tax receipts. That principle was given the force of law by the scorekeeping rules included in the conference report accompanying the Omnibus Budget Reconciliation Act of 1990.

Although somewhat arbitrary, the principle is consistent with the current structure of the budget process, which assumes a clear distinction between the budgetary effects of discretionary spending on the one hand and of mandatory spending and revenues on the other. The Balanced Budget Act controls mandatory spending and revenues by the pay-as-you-go process. Separate caps on budget authority and outlays limit discretionary spending. Congressional controls on revenues and mandatory spending involve a five- or ten-year horizon, but the controls on discretionary spending apply only to the budget year. The costs of bills affecting revenues or mandatory spending are measured as deviations from current law, whereas appropriation bills are assigned their full cost. In addition, the current process lacks a mechanism for charging or crediting the Appropriations Committees with changes in revenues resulting from changes in funding levels. Moreover, if savings were scored for increases in administrative funding, costs would have to be shown if administrative funding was reduced. Such savings or costs might arise from even small increases or decreases in many budget accounts, thus significantly complicating the scoring of appropriation bills.

In two instances, special provisions have been made for enforcement initiative --in both cases for the Internal Revenue Service (IRS)--but the basic scorekeeping rule has been maintained. The Budget Committees and the Office of Management and Budget agreed to include revenues resulting from increased spending on IRS enforcement as part of the projected savings from the bipartisan budget agreements

of 1989 and 1990. However, the additional revenues were not attributed to a particular bill and were not reflected in the Congressional scorekeeping system.

Section 25 of the budget resolution for 1995 provided that, for purposes of points of order under the Congressional Budget Act, the discretionary spending limits and the allocations of spending authority to the Appropriations Committees would be increased to reflect the amounts of additional budget authority and outlays provided for the IRS compliance initiative. That provision did not create problems under the Balanced Budget Act only because the budget resolution held discretionary spending below the limits established in the act. Also, no increase in revenues was assumed to result from the additional administrative spending. Section 209 of the budget resolution for 1996, however, repealed the special allowance for the IRS. Although the resolution assumes that the IRS compliance initiative will be fully funded, the conferees expressed concern about efforts to circumvent the discretionary caps and felt that the IRS should not be funded outside the caps.

CONCLUSION

Fraud and abuse clearly exist in Medicare, just as in all other public and private health plans, but estimates of potential losses from fraud and abuse are inherently speculative. If HCFA and private insurers had good information about the extent of

the problem, they would know how to eliminate it. Moreover, fraud and abuse are not easily trimmed from the edges of the program but are marbled throughout the system. In Medicare, as elsewhere in the federal budget, there is no line item labeled "fraud, waste, and abuse."

The General Accounting Office and others have made many suggestions for reducing what they see as wasteful spending by pricing Medicare services and procedures more competitively and choosing health care providers more selectively. Some of those proposals could significantly slow the growth of spending in Medicare. In contrast, several considerations limit the savings to be expected from new payment safeguard initiatives. No savings should be expected without an assurance that the funding intended for specific initiatives to promote program integrity will be used for those purposes and that funding will be maintained in future years. Even with such assurances, and with some evidence of the savings achieved by similar initiatives in the past, the amount of savings to be expected is uncertain because diminishing returns are sure to set in as additional resources are devoted to those activities. Finally, CBO must evaluate any legislative proposal using the scorekeeping rules established by law and longstanding practice. If the Congress finds that spending more on efforts to further program integrity would represent good Medicare policy, however, it can and should ensure the necessary funding.

POSSIBILITIES OF FRAUD IN MANAGED CARE

Question (Senator Hatch)

Mr. Van de Water, you mention in your testimony that many of the elements of Medicare that have led to excessive spending are embedded in the legislation which created the program thirty years ago. Specifically you refer to the emphasis on unmanaged fee-for-service care and the cumbersome procedures required to revise certification requirements and payment rates. As you know, 10 percent of Medicare beneficiaries are currently in a managed care arrangement and there appears to be growing support to modify current law so that more beneficiaries could take advantage of managed care services. To what extent will allowing more beneficiaries in manage care help solve some of the fraud and abuse problems we see in the fee-for-service setting? And I guess another way of looking at this is whether you see aspects of managed care that may be ripe for new types of fraudulent activity?

Answer

Increased enrollment in managed care plans will reduce the opportunities for certain types of fraudulent and abusive activities in Medicare but increase the chance of others. Under fee-for-service care, unethical providers may bill for services that are not provided, perform unnecessary services, or charge excessive rates. Under managed care, abuse may come in the form of withholding appropriate services.

(3) – QUESTION FOR MR. VAN de WATER

Mr. Van de Water, you mention in your testimony that many of the elements of Medicare that have lead to excessive spending are embedded in the legislation which created the program thirty years ago.

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ANSWER: We believe that managed care plans are not immune to fraud schemes that are perpetrated on the program in the fee-for-service sector. Many vulnerabilities are the same, especially those in the financial area. However, managed care plans, especially risk-based Health Maintenance Organizations (HMOs), are especially vulnerable to:

- Incentives to skimp on care;
- New forms of financial fraud, especially
  - -- Gaming the reimbursement rate (the "adjusted community rate;"
  - -- Questionable relations with subcontractors and providers, including arrangements to disguise profits;
  - -- Failure to fairly reimburse providers; and
  - -- Making false claims for special populations, such as ESRD, deinstitutionalized, and dually eligibles (Medicare and Medicaid), for whom higher reimbursement is paid; and

- Instability, due to fraud and mismanagement.

Since many vulnerabilities are the same, current oversight systems for managed care organizations are similar to those for fee-for-service. However, many of these traditional systems have not yet been fully developed for managed care plans, so they need closer scrutiny. We have found it necessary to look more closely at marketing practices, and subcontractor arrangements. In Medicaid, we have to examine State oversight systems detecting fraudulent and abusive practices.

We must be vigilant to vulnerabilities presented by managed care plans. Fraud in this area not only impacts the plans directly through excessive costs, but also the government, which eventually pays for these costs through higher capitation payments, and the beneficiaries, through higher copayments and deductibles. To that end, we are trying out new methods for detecting fraud and abuse, such as surveys and outcome measures. In addition, we would recommend that government contracts with managed care plans contain provisions that require a proactive policy to detect and avoid potential fraud.

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